2024

St. Luke's

# Benefits Summary Book

# Contents



*This booklet provides you with an overview of your benefit plans at St. Luke's Hospital. This overview covers only the key features of the plans. If any conflict occurs between this material and the plan documents that define this program, the plan documents will govern.*

*The benefits plans sponsored by St. Luke's and its affiliates are designed to qualify as church plans within the meaning of Section 414(e) of the Internal Revenue Code of 1986 and Section 3(33) of ERISA and, as such, the plans are considered exempt from ERISA.*

*Revised 10/2023*

## Glossary

**Allowed Amount –** The amount that St. Luke's determines is the appropriate rate.

**Birthday Rule –** When both you and your spouse have coverage for your dependents, only one parent's insurance will pay as primary. This is determined by the birthday rule, which states that the parent who has the first birthday of the year will be the primary insurance carrier.

**Coinsurance –** The percentage of a covered charge that the plan will pay. For instance, if the coinsurance is 70%, and you have a bill for $100, the plan will pay $70 and you will pay $30 (after you've paid your deductible or copay).

**Copayment –** The set dollar amount you pay for certain services in our medical plans. For instance, when you have an appointment with your physician, you will pay a $20.00 copay at the time of your office visit if you are covered under the Premium medical plan.

**Deductible –** The amount you must pay for any covered charges before the plan will begin to pay benefits. For instance, if you have a $500 deductible, you'll be responsible for paying the first $500 of medical expenses you have each year. After that, the plan will begin to pay benefits. Copays do not apply toward the deductible.

**Child Dependent Status –** Any child, up to age 26. See also section entitled "Benefit Eligibility" for additional information regarding eligibility for dependent status.

**Dental UCR Charge or the Usual, Customary and Reasonable Charges** – which refers to the base amount that is treated as the standard or most common charge for a particular medical service when rendered in a particular geographic area; UCR charges should not exceed the amount ordinarily charged by most providers for comparable services or supplies in the locality where the services or supplies are received.

**Essential Health Benefits –** Any medical expense that falls under the following categories, as defined under the Affordable Care Act: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs (excluding all preferred prescription drugs for which there are medically appropriate generic prescription drugs available, all non-preferred prescription drugs and all other non-covered or non-formulary prescription drugs); rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, services including oral and vision care, etc.

**Non-Duplication of Benefits –** This is the method St. Luke's uses to coordinate our medical, dental, and vision benefits with other coverage. This means when another plan pays first, St. Luke's plan pays only the amount needed to bring your total benefits to St. Luke's plans' benefit level.

**Out-of-Pocket Maximum –** The maximum amount you'll have to pay for covered medical expenses that are identified as Essential Health Benefits in one year. This includes the amount you pay for the plan's copays, coinsurance and deductible. In addition, the amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are included in the Out-of-Pocket Maximum for your elected coverage option.

**Plan Year –** The benefit plan year is a calendar year running from January 1st to December 31st. Unless otherwise noted or communicated, benefit elections and plan provision are effective based upon the plan year.

**Qualifying Event –** When an employee experiences a change that allows the employee to enroll, change, or stop benefits outside the Open Enrollment time period. Qualifying events include marriage, divorce, birth, death, or other changes outlined in the "When You Can Make Changes" section of this book. You must provide appropriate documentation and may only enroll within 31 days of the event.

**Spousal Coverage –** St. Luke's provides coverage to employees, spouses and children. If a spouse has other insurance available (for example: through employer or other plans) coverage is still available through St. Luke's but different premiums will apply. Annually, team members will need to complete the Spousal Affidavit/Certification Form and submit the completed form to the Benefits Office. If not submitted, spousal rates will apply. (Appendix Section A)

**Term Life Insurance –** The life insurance you automatically receive from St. Luke's and/or the supplemental coverage you elect "terms" or ends with your employment. You may elect to convert your supplemental life coverage (within 31 days of your termination date) to an individual policy when you leave St. Luke's. Your premiums would be set by the insurance carrier at the time the coverage is converted.

# Important Benefit Contacts

## Medical & Dental

United Medical Resources
umr.com
Group Number 76410532
Phone: 800-826-9781

## Vision

VSP
vsp.com
Phone: 800.877.7195

## Prescriptions

Capital Rx
https://www.cap-rx.com/members
Phone: 888-302-2779
Prior Authorization

St. Luke's Pharmacy
314-205-6023

## PRUDENTIAL

Long Term Disability
Phone: 800-842-1718
Leave Management
Phone: 877-367-7781
St. Luke's Leave Support 314-205-6680

## UNUM

Life Insurance
Group Number 423744
Phone: 800-421-0344

## VOYA VOLUNTARY BENEFITS

Accident Coverage
Critical Illness Coverage
Phone: 877-236-7564

## ARAG

Legal Insurance
www.araglegalcenter.com
Phone 800-247-4184

## Flexible Spending Accounts

Medical Spending & Dependent Spending Accounts
TriStar Systems
Account Login: www.fsa.help/login
Phone: 314-576-4022 – Option #1 or 800-727-0182, Option #1
Reps available Mon-Friday, 8am – 5pm
www.fsa.help/login

## Health Savings Account

Bank of America HSA Customer Care Center
866-791-0250
Business days, 7am-10pm CST Bank of America HSA web address
www.bankofamerica.com/benefitslogin

## Matched Savings Plan (401(k))

Fidelity
www.netbenefits.com/stlukeshospital
800-343-0860

## Retirement Plan

Aon
Phone: 866-STLUKE5
866-785-8535
Type in Address bar
https://ypr.aon.com/stlukes

## St. Luke's Hospital Benefits Office

314-205-6016
Fax: 314-336-5225 or 314-336-5234

***The benefits offered under the "Important Benefits Contacts" listed above are provided under plans that constitute church plans within the meaning of Section 414(e) of the Internal Revenue Code and Section 3(33) of the Employee Retirement Income Security Act of 1974 ("ERISA"). Accordingly, such plans are considered exempt from ERISA.***

# Benefit Eligibility

**Who is Eligible?**
Eligibility depends upon your employment status and your length of service with St. Luke's.

| Coverage | Who is Eligible? |
|---|---|
| Medical, Dental, Vision, Flexible Spending Accounts | Full-time employees who are scheduled, and actually work at least 36 hours per week. Part-time employees who are scheduled, and actually work at least 16 hours per week. |
| Life Insurance | Full-time and part-time employees as defined above. |
| Long-Term Disability | Full-time employees as defined above. |

**Medical Affordable Care Act (ACA) Coverage**
Individuals not in a benefit eligible status who meet the ACA full-time status (an average of 130 hours monthly for a total of 1560 hours in a continuous 12-month period, October 1st to September 30th) may be eligible for **medical coverage** only in the following benefit year. Individuals meeting ACA eligibility criteria will be notified by the Benefits Office if they are able to enroll for medical benefits.

**Dependent Coverage**
Under the medical, dental and vision plans, you can elect to cover your spouse and each of your children until the age of 26. Your children can include your natural or adopted children and your stepchildren. You may cover children age 26 and over who are dependent upon you because of a physical, mental health, or substance use disability and incapable of self-support. The Plan does not cover grandchildren or spouses of dependents.
You must notify the Benefits Office and submit proof of the child's disability status.

**You must be able to provide proof of eligibility upon enrolling dependent children.**

**What is Needed for Proof of Eligibility**

| Dependent | Proof of Eligibility | Primary Residence |
|---|---|---|
| Natural Child | Birth certificate, affidavit of birth or Baptismal Certificate | Anywhere |
| Adopted Child | Adoption or placement Papers | Anywhere |
| Stepchild | Marriage Certificate and Birth certificate | Anywhere or per Court Order |
| Guardian | Court or Guardianship papers | Anywhere or per Court Order |
| Disabled Dependent | Physician's Statement or Social Security Disability | Anywhere |
| Children of Minor Dependent Children | Court papers for adoption or Guardianship | Anywhere |

## When You Can Make Changes

### What Happens If You Decline Coverage?

If you decline coverage for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and/or your dependents in the future, as long as you enroll within 31 days (60 days in certain circumstances) of when your other coverage ends or when you experience a change in status/qualifying event. When you are enrolling due to a loss of other coverage, **you must supply supporting documentation of loss of other coverage to complete the enrollment.**

You always have the ability to enroll yourself and/or your dependents at the next open enrollment period.

Contact the Benefits Office for more information about changing your benefits coverage.

The choices you make during the enrollment period remain in effect for the full plan (calendar) year unless you experience a change in status or a qualifying event.

**A change in status / qualifying event includes:**

- Marriage
- Divorce
- Birth, adoption, or placement for adoption of a child
- Death of a spouse and/or dependent
- Loss or gain of coverage due to a change in your spouse's employment status
- Change in your employment status from eligible (**16 hours or more per week**) to ineligible status (**less than 16 hours per week**) or vice versa
- You or your child's loss of coverage/eligibility because you or your dependent has reached the age of 26
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your dependents.
- You or your dependent child losing coverage or becoming eligible for coverage under Medicaid or a state Children's Health Insurance Program (CHIP)
- Medicare eligibility for employee or spouse;
- Going on a leave of absence under the Family and Medical Leave Act;
- A significant increase or decrease in the cost of coverage; or
- Any other change that is permissible under IRS regulations and ruling as determined by St. Luke's.

Any changes to your elections must be consistent with your change in status or qualifying event. For example, if you are married and get divorced mid-year, you may cancel coverage for your ex-spouse but you may not elect no coverage for yourself.

**When you experience a qualifying event, you must:**

- Print and complete the Enrollment form (on the Intranet) and submit it to Human Resources within **one month (31 days, provided, however, if the qualifying event is you or your dependent child becoming eligible for or losing coverage under Medicaid or CHIP, then 60 days)** from the change in status /qualifying event to change your elections. (For example, if you get married on March 2, 2024, and wish to add your new spouse to your plan, you must return completed paperwork by April 2, 2024); and

- Provide appropriate documentation, such as a birth certificate or a marriage certificate.

**If you fail to do either of these things, you will not be able to change your benefit coverage until the next annual enrollment or until your next qualifying event / change in status.**

**Once your request to change your benefit elections is approved, the changes and premium amounts will be made effective retroactive to the date of the change in status**.

If you experience a change in **employment status from full-time to part-time, or part-time to full-time,** you may be able to add or drop your coverage consistent with the change in employment status.

**How Cost and Coverage Works**

While St. Luke's pays the majority of the cost of coverage, you pay a portion of the cost through payroll deduction. Your cost of coverage depends on the option and coverage category you choose, as well as on your employment status. For more information on coverage costs, refer to the monthly contribution rate sheet included in this booklet, distributed at New Hire Orientation or Employee Self Service (ESS). Keep in mind, your portion of the cost for many benefits will be paid with pre-tax dollars, which lowers your taxes and increases your take-home pay.

**When coverage begins depends on the type of coverage**

| Coverage | Who Pays for Coverage | Effective |
|---|---|---|
| Medical, Dental, Vision | St. Luke's and you (on a pre-tax basis) | Immediately<br>(Election must be made online within 31 days of employment) |
| Life Insurance | | |
| • Basic Life | St. Luke's | Immediately |
| • Supplemental Term Life | You (on an after-tax basis) | Immediately<br>(Enrollment must be completed within 31 days of plan eligibility) |
| • Dependent Term Life | You (on an after-tax basis) | Immediately<br>(Enrollment must be completed within 31 days of plan eligibility) |
| Long-Term Disability | ***For full-time employees only*** | |
| o Basic | St. Luke's | Immediately |
| o Premium | You (on a pre-tax basis) | Immediately<br>(An election form must be completed within 31 days of employment or plan eligibility) |
| Health Savings Accounts | St. Luke's and You (on a pre-tax basis) | First day of the month following election of HDHP and account set up |
| Flexible Spending Accounts | You (on a pre-tax basis) | Immediately<br>(Election must be made online within 31 days of employment) |

**When Coverage Ends:**

**For You**

Generally, your St. Luke's benefits coverage will end on the earliest of:

- Midnight on the last day of the month in which you terminate employment or otherwise cease to be a benefit eligible employee;
- The last day of the Plan Year if you cancel coverage during annual enrollment or fail to enroll during an active annual enrollment;
- The date you stop making the required plan contribution; or
- The date the plan is discontinued.

**For Your Dependent**

Your dependent's coverage will end on the earliest of:

- Midnight on the date your coverage ends for any reason;
- The last day of the month in which the qualified dependent ceases to be eligible;
- The date you stop making the required contribution for dependent coverage; or
- The date all dependent coverage under the plan terminates.

NOTE

If you do not notify the plan within thirty-one (31) days (or within sixty (60) days of becoming eligible for or losing coverage under Medicaid or CHIP) of a change in status event that causes your dependent to lose eligibility under the plan, the ineligible dependent's coverage will still terminate as of the last day of the month in which he or she became ineligible.

If the removal of the dependent results in a lower contribution, contributions will be reduced accordingly moving forward from the first day of the pay period after we were notified. Any prior contributions already paid from the date coverage terminated will not be refunded.

**See Continuation of Coverage section for eligibility details.**

# St. Luke's Employee Benefits

## 2024 Employee Contribution Rates

**Semi-monthly Payroll Deductions**

**MEDICAL**
**FT = min .75 FTE**
**PT = min .4 FTE**

| | Employee | *Employee + Spouse | Employee + Children | *Family |
|---|---|---|---|---|
| **Basic** | | | | |
| Full Time | $33.24 | $154.03 | $126.08 | $196.76 |
| Part Time | $126.08 | $266.92 | $218.92 | $385.08 |
| **Premium** | | | | |
| Full Time | $87.57 | $251.09 | $209.42 | $326.53 |
| Part Time | $203.09 | $439.41 | $363.98 | $539.11 |
| **High Deductible** | | | | |
| Full Time | $18.99 | $85.99 | $71.22 | $121.86 |
| Part Time | $97.06 | $204.15 | $168.28 | $292.24 |

***Additional semi-monthly charge for Spousal Coverage when other coverage is available or Spousal Affidavit/Certification is not received** **+$75.00**

**DENTAL**
**FT = min .9 FTE**
**PT = min .4 FTE**

| | Employee | Employee + Spouse | Employee + Children | Family |
|---|---|---|---|---|
| **Basic** | | | | |
| Full Time | $2.65 | $10.14 | $8.21 | $18.66 |
| Part Time | $6.68 | $16.57 | $13.56 | $26.00 |
| **Premium** | | | | |
| Full Time | $7.24 | $22.89 | $18.71 | $36.34 |
| Part Time | $13.87 | $31.75 | $26.00 | $46.18 |

**VISION**
**FT = min .9 FTE**
**PT = min .4 FTE**

| | Employee | Employee + Spouse | Employee + Children | Family |
|---|---|---|---|---|
| **Basic** | | | | |
| Full Time & Part Time | $2.20 | $5.16 | $5.52 | $8.02 |
| **Premium** | | | | |
| Full Time & Part Time | $4.32 | $9.92 | $10.60 | $13.85 |

**Critical Illness and Accident premiums are not listed. Individualized rates are determined by age, selections made and smoking status. Rates will display during on-line enrollment.**

# St. Luke's Employee Benefits

## 2024 Employee Contribution Rates

**Monthly Payroll Deductions**

**LONG TERM DISABILITY**

| | Basic | Premium |
|---|---|---|
| **Age Group** | Provided by St. Luke's at no cost to you | Rate per $100 of **Monthly** Salary |
| Less than 25 | | $0.029 |
| 25-29 | | $0.036 |
| 30-34 | | $0.071 |
| 35-39 | | $0.108 |
| 40-44 | | $0.161 |
| 45-49 | | $0.218 |
| 50-54 | | $0.301 |
| 55-59 | | $0.319 |
| 60-64 | | $0.337 |
| 65-69 | | $0.350 |
| 70+ | | $0.359 |

To calculate monthly premium: Hourly Rate x 174 x FTE ÷ 100 x LTD Rate

**EMPLOYEE SUPPLEMENTAL LIFE**

| | Full Time | Part Time |
|---|---|---|
| **Attained Age** | **Rate per $1,000 of Annual Salary** | **Rate per $10,000 Unit** |
| Less than 25 | $0.050 | $0.50 |
| 25 – 29 | $0.060 | $0.60 |
| 30 – 34 | $0.080 | $0.80 |
| 35 – 39 | $0.090 | $0.90 |
| 40 – 44 | $0.122 | $1.22 |
| 45 – 49 | $0.202 | $2.02 |
| 50 – 54 | $0.298 | $2.98 |
| 55 – 59 | $0.537 | $5.37 |
| 60 – 64 | $0.926 | $9.26 |
| 65 – 69 | $1.532 | $15.32 |
| 70 – 74 | $2.351 | $23.51 |
| 75 – 79 | $3.607 | $36.07 |
| 80 - 84 | $3.607 | $36.07 |
| 85+ | $5.184 | $51.84 |

Calculate Monthly Premium

Salary x # increments = (round up $) divide by 1,000 = then multiply that amt. by age amt on table above = Monthly Cost $_____

**Dependent Life**

| Plan | Cost Per Month |
|---|---|
| $20,000 Spouse / $10,000 Child | $2.35 |
| 5,000 Spouse / $2,500 Child | $1.17 |

# Medical Benefits

St. Luke's has designed a flexible system of electing medical coverage to best suit your personal situation.

**Your Options:**

1. Basic Plan Option;
2. Premium Plan Option;
3. High Deductible Health Plan (HDHP) with Health Savings Account: or
4. Decline Coverage

See Schedule of Benefits for each of the plan options for specific plan information.

**Basic Plan Option**

The Basic Plan offers a flexible 3-tier system. You may choose to receive care from any of the three levels of benefits: however, if you receive care from a Tier 1 provider, you will pay less out of pocket. This plan allows for wellness care to be paid at 100%. This plan provides for lower premiums but requires a higher level of out of pocket expenses. This plan choice is ideal for those who are comfortable with paying more as care is received and prefer to have a lower premium.

**Premium Plan Option**

The Premium Plan also offers three tiers of care, with the least out of pocket expenses in Tier 1 and 100% wellness care in Tier 1. The Premium Plan has higher monthly premiums, but lower levels of deductibles and co-pays. This plan choice is beneficial for those individuals who would prefer to pay less as care is received and are comfortable with a higher premium.

**HDHP with HSA Option**

The High Deductible Health Plan (HDHP) presents a different way to manage health care costs and provides an opportunity to save for future or post- retirement medical expenses. The plan offers three tiers of care with the lowest deductible in Tier 1, or the St. Luke's network. This plan pays for 100% of wellness/preventative care. The HDHP offers the lowest premiums of the three plans. It also has the highest deductible amount, and until the deductible is met, the employee is responsible for the full amount of the bill rather than a co-payment. Along with the HDHP, participants are eligible to enroll in a Health Savings Account (HSA). St. Luke's will provide an annual contribution to all HSA accounts. An HSA also allows participants to contribute on a tax-advantage basis to this account, and it can be used to cover eligible out of pocket costs or, it can be saved and allowed to grow. This account is vested immediately and can be used for post- retirement eligible medical expenses as well.

**NOTE**

- Pre-certification is required for inpatient hospitalizations on all plan options. A deductible may be imposed if a hospitalization is not pre-certified (please refer to Pre-certification requirements section in Schedule of Benefits).

Care received outside the United States is excluded from coverage under these plans except in an emergency situation.

**Prescription Drugs**

Prescription drug co-payments are different for each of the medical plan options. As outlined in the Schedule of Benefits, a discounted co-pay is provided for first fills and refills at St. Luke's Pharmacy for the Basic and Premium Plan.

The High Deductible Health Plan requires prescriptions to be paid at the price that St. Luke's is charged. These costs can be reimbursed by utilizing money set aside in the HSA account.

The amount of any co-pays, coinsurance, or deductibles you pay for covered prescription drugs are included your selected medical plan option Out-of-Pocket Maximum amounts.

Prescriptions considered non-formulary are not covered. Prescriptions drug co-pays for any preferred prescription drug for which there is no medically appropriate generic prescription drug available and for generic prescription drugs are included in the Out-of-Pocket Maximum amounts. However, the amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are not included in the Out-of-Pocket Maximum amounts. Prescriptions can be filled at participating pharmacies or through the mail for maintenance medications.

If you or your physician chooses a brand name drug (e.g. preferred drug, non-preferred drug or other drug) when a suitable generic drug is available, you will pay the generic co-pay plus the average wholesale price difference between the generic and the brand name drug.

**Passport to Wellness**

Passport to Wellness (PTW) is available to all employees. This program is designed to encourage all employees to be an active partner in their health by providing health-related events and "challenges" throughout the year. At enrollment blitzes employees get FREE biometric screenings (for cholesterol and glucose), blood pressure, weight/waist measurements and consultation on their individual results. The PTW Program is open to all benefit eligible employees and is optional. St. Luke's encourages PTW participation by offering a bonus to benefit eligible PTW enrollees.

PTW is offered through a third-party administrator, Navigate Wellbeing. Navigate Wellbeing hosts the site www.stlukes.livehealthyignite.com. For more information, please visit the intranet, Departments/Passport to Wellness or call 636-685-7719 or email passporttowellness@stlukes-stl.com

**Benefit Coverage for Bariatric Surgery**

St. Luke's Health Plans provides coverage of bariatric surgery. Eligibility criteria exist for those considering surgery. The MyNewSelf bariatrics program at St. Luke's Des Peres Hospital is our Tier 1 provider. MyNewSelf is an accredited program that offers several weight loss surgery options as well as specialty care during weight loss surgery, pre-surgery education, post-surgery classes and support groups and personal nutrition and lifestyle counseling and support. MyNewSelf is located at St. Luke's Des Peres Hospital, 2355 Dougherty Ferry Rd, Suite 420, St. Louis, MO 63122. For coverage details, contact UMR (United Medical Resources) at 1-800-826-9781.

# Medical Plans

## How the Tiers Work

| **Tier 1 – St. Luke's Network** | UHC = United Healthcare |
|---|---|
| **Facilities** | |
| **Tier 2 is the highest level of coverage provided by this plan for services not provided by St. Luke's, with the exceptions of NICU, PICU, and Burns.** | St. Luke's Hospital<br>St. Luke's Des Peres Hospital<br>St. Luke's Pharmacy<br><br>Surrey Place<br>St. Luke's Rayus Radiology (CDI)<br>St. Luke's Sleep & Medicine Center<br>St. Luke's Home Health Services<br>St. Luke's Hospice Services<br>Gateway Endoscopy Center<br>All UHC Network Hospice Facilities<br>All UHC Network Outpatient Dialysis Centers<br>All UHC Network Private Duty Nursing Services<br>Heart Care Specialists Ambulatory Surgery Center<br>City Place Surgery Center<br>St. Luke's Surgery Center of Chesterfield |
| **Physicians** | All UHC Network Primary Care Physicians<br>All UHC Network Specialists |

| **Tier 2 – UnitedHealthcare Choice Plus Network** | |
|---|---|
| **Facilities** | All UHC Network Facilities All Other Pharmacies (All participating Capital Rx Facilities) |

| **Tier 3 – Out of Network** | |
|---|---|
| **Facilities** | All Other Facilities Not Considered Tier 1 or Tier 2 |
| **Physicians** | All Other Physicians Not Considered Tier 1 or Tier 2 |

# St. Luke's Hospital

## Basic Plan
## 2024 SCHEDULE OF BENEFITS

This Summary of Benefits provides a simplified overview of the medical plan. The plan is governed by the terms of legal documents. We have taken care to ensure that the following are accurate. However, if there is a conflict between this Summary of Benefits chart and the legal documents, the legal documents will be followed.

| **DESCRIPTION OF MEDICAL BENEFITS – Basic Plan** | **ST. LUKE'S NETWORK** Tier 1 | **UNITED HEALTHCARE NETWORK** Tier 2 | **OUT OF NETWORK** Tier 3 |
|---|---|---|---|
| **Calendar Year Deductible**<br>• Individual | $400 | $1,200 | $3,000 |
| • Family | $450 | $3,240 | $5,120 |
| **Calendar Year Out-of-Pocket Maximum (Includes deductible amount listed above)**<br>• Individual | $1,650 | $5,780 | $10,000 |
| • Family | $3,450 | $13,520 | $18,800 |
| **Pre-Certification Requirements***<br>• Inpatient<br>o Elective admissions must be pre-certified prior to any elective admission to a Hospital, Hospice Facility, Residential Treatment Facility or Skilled Nursing Facility, or within 2 working days for emergency admissions.<br>o A $500 deductible for each period of confinement may be imposed for failure to pre-certify inpatient confinements. This deductible does not apply to the Out-of-Pocket maximum.<br>• Treatment Plan Certification<br>o Treatment plans may be required for some services (i.e., Chemotherapy) in order to determine length and type of service for payment purposes.<br>• Additional Care Requiring Precertification<br>o Clinical Trials<br>o Spinal/Back Surgery for Tier 2 and Tier 3<br>o Pain Management including injections for Tier 2 and Tier 3<br>***All plan options may require pre-certification, pre-determination, preauthorization, treatment plan information, or a letter of medical necessity depending upon the specific medical treatment or procedure. You may contact UMR at 1-800-826-9781 for specific information.** | | | |
| **Hospital / Facility Services**<br>• Inpatient | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Outpatient – CT Scan, MRI and PET Scan | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Emergency Room Services**<br>Only Medical Emergencies as defined by the Plan are covered. Copay waived if patient is admitted as an Inpatient, then Inpatient benefits apply | $250 copay<br>then 100%<br>No deductible | $250 copay<br>then 100%<br>No deductible | $250 copay<br>then 100%<br>No deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Basic Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Urgent Care Facility** | $35 copay<br>then 100%<br>No deductible | $50 copay<br>then 100%<br>No deductible | 50%<br>After deductible |
| **Pre-Admission Testing** | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Outpatient Surgery**<br>At Hospital or Ambulatory Surgical Center<br>• Facility | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Surgeon and Anesthesiologist<br>• Pathologist and Radiologist | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| **Voluntary Second Surgical Opinion**<br>• Primary Care Physician | $15 copay 100% No deductible | | 50%<br>After deductible |
| • Specialist | $20 copay 100% No deductible | | 50%<br>After deductible |
| **Physician Office Services –**<br>All services performed in the Physician's office including:<br>• Office visits and Telehealth visits<br>• Surgical procedures<br>• Laboratory and x-ray (test obtained and processed in office only)<br>• Eye Exam, limited to **1 per calendar year**<br>• Allergy injections<br>• Allergy testing<br>• Chemotherapy administration, injectables, medications, casts, and other treatment materials (see Pre-cert requirements).<br>- Primary Care Physician | $15 copay for office visit<br>$0 copay for telehealth visit<br>then 100% No deductible | | 50%<br>After deductible |
| - Specialist | $20 copay for office visit<br>$0 copay for telehealth visit<br>then 100% No deductible | | 50%<br>After deductible |
| **Physician Services Other – Inpatient or Outpatient**<br>• Surgeon and Assistant Surgeon<br>• Anesthesiologist, Radiologist and Pathologist – services rendered by a Tier 3 Anesthesiologist, Radiologist or Pathologist at a Tier 1 or Tier 2 facility will be paid at the higher coinsurance level of the facility. | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| **Labs Performed Outside Physician Office – Diagnostic** | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Wellness Care**<br>• Preventative/Routine adult office visit (18yrs+), including diabetes screening, routine lab and x-ray, counseling and screening for HIV, as necessary to obtain covered preventative services, **1 per calendar year** (all appropriate immunizations per UMR guidelines)<br>- Facility | 100%<br>No deductible | 100%<br>No deductible | 50%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Basic Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| • Well woman gynecological exams and pap smear, including routine lab processing, as necessary to obtain covered preventative services<br>• Obstetrical Care, as necessary to obtain specified preventative services including routine prenatal visits, tobacco cessation counseling and immunizations (note: this does not include delivery or high risk maternity services)<br>• Screening and counseling for STD's and domestic violence<br>• HPV testing and counseling (30yrs+ 1 every 3 years)<br>• 2 ultrasounds covered at 100% of allowable, gestational diabetes screening (2 per pregnancy)<br>• Approved contraceptive methods, including sterilization<br>• Breastfeeding supplies, counseling and support, including rental of breast pump. Covers purchase of non-hospital grade breast pump or new supplies for existing pump (1 per pregnancy)<br>- Facility | 100%<br>No deductible | 100 %<br>No deductible | 50%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Mammograms<br>- Facility | 100%<br>No deductible | | 50%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Colonoscopy<br>Limited to 1 routine test every 10 years starting at age 45. Includes anesthesia.<br>- Facility | 100%<br>No deductible | | 50%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Well man PSA, including routine lab, limited to **1 per calendar year.**<br>- Facility | 100%<br>No deductible | | 50%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Basic Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| • Well baby care/pediatric exams (up to age 18), including all appropriate immunizations per UMR guidelines, lab and x-ray. (Note: annual school physicals are not covered.)<br>- Facility | 100%<br>No deductible | | 50%<br>No deductible |
| - Primary Care Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Other preventative/routine care as required under the Women's Preventative Services | 100%<br>No deductible | | 50%<br>No deductible |
| **Mental/Nervous Disorders (including autism spectrum disorder care and applied behavior analysis programs)**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | $15 copay<br>100% No deductible | | 50%<br>After deductible |
| - Specialist | $20 copay<br>100% No deductible | | 50%<br>After deductible |
| **Alcoholism and Drug Abuse**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | $15 copay<br>100% No deductible | | 50%<br>After deductible |
| - Specialist | $20 copay<br>100% No deductible | | 50%<br>After deductible |
| **Skilled Nursing Facility**<br>All stays are pre-certified for medical necessity. | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Clinical Trials**<br>• Includes services typically provided for other conditions<br>• *Excludes investigational items or devices, data collection costs or services outside established standards of care. | 85%<br>After deductible* | 65%<br>After deductible* | 50%<br>After deductible* |
| **Home Health Care**<br>Must be within 14 days of a Hospital or Skilled Nursing Facility confinement, with a maximum of 90 visits (in combination with Outpatient Hospice Care) in a 12-month period. (Excludes custodial care). | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Hospice Care Services**<br>• Inpatient (See pre-certification requirements) | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Outpatient | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Basic Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Private Duty Nursing**<br>$5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care).<br>• Inpatient | 50%<br>After Tier 2 deductible | | 50%<br>After deductible |
| • Outpatient | 85%<br>After Tier 2 deductible | | 50%<br>After deductible |
| **Maternity**<br>Female Employees and Dependents | Same as any other Illness | | |
| **Newborn**<br>Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren). | Same as any other Illness | | |
| **Ambulance Services** | 85%<br>After Tier 1 deductible | | |
| **Physical Therapy**<br>Maximum of 60 visits in combination with occupational therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Physician<br>- Primary care Physician | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 50%<br>After deductible |
| - Specialist | $20 copay-100%<br>No deductible | $40 copay-100%<br>No deductible | 50%<br>After deductible |
| **Occupational Therapy**<br>Maximum of 60 visits in combination with physical therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Physician<br>- Primary care Physician | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 50%<br>After deductible |
| - Specialist | $20 copay-100%<br>No deductible | $40 copay-100%<br>No deductible | 50%<br>After deductible |
| **Speech Therapy**<br>Maximum of 60 visits in combination with physical therapy and occupational therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Physician<br>- Primary Care Physician | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 50%<br>After deductible |
| - Specialist | $20 copay-100%<br>No deductible | $40 copay-100%<br>No deductible | 50%<br>After deductible |
| **Habilitation Services** | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **Inhalation Therapy and Radiation Therapy**<br>• Facility | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| • Physician<br>- Primary Care Physician | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 50%<br>After deductible |
| - Specialist | $20 copay-100%<br>No deductible | $40 copay-100%<br>No deductible | 50%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Basic Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Transplant Services:**<br>- Physician<br>- Facility – Designated Transplant Centers of Excellence | 90%<br>After Tier 2 deductible | | Not Covered |
| **Transplant Services:**<br>- Travel and housing<br>Maximum Benefit per transplant | $10,000 | | Not Covered |
| **Durable Medical Equipment – Charges over $500 must be pre-certified.** | 75%<br>After Tier 2 deductible | | 50%<br>After deductible |
| **Artificial Limbs/Prosthesis** | 80%<br>After Tier 2 deductible | | 50%<br>After deductible |
| **Chiropractic Care:**<br>**Maximum of 20 visits. (Such visit limit does not apply when chiropractic care is coded as a mental health or substance use disorder service.)** | $30 copay after deductible | $35 copay after deductible | Not covered |
| **All Other Covered Facility Charges** | 85%<br>After deductible | 65%<br>After deductible | 50%<br>After deductible |
| **All Other Covered Physician Charges** | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| **Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders** | 85%<br>After Tier 1 deductible | | 50%<br>After deductible |
| **Pharmacy Benefits** | | | |
| **Prescription Drugs. The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office. (*Refer to Appendix Section D for additional information)***<br>• Retail – (Prescriptions refilled at Tier 1 network will be discounted). | **<u>Tier 1 & Tier 2-3 First Fills (Copay)</u>**<br>Generic - $12.00<br>Preferred - $25.00<br>Non–Preferred - $50.00 | | **<u>Tier 2 – 3 Refills (Copay)</u>**<br>Generic - $18.00<br>Preferred - $30.00<br>Non-Preferred - $75.00 |
| • Specialty Rx/30-day All specialty prescriptions must be filled through Capital Rx or at St. Luke's Hospital pharmacy | **<u>Copay $150.00</u>** | | |
| • Mail Order / 90-day<br>Generic<br>Preferred Brand<br>Non-Preferred Brand | <br>$24.00 copay<br>$50.00 copay<br>$100.00 copay | | <br>$36.00 copay<br>$67.50 copay<br>$187.00 copay |

**Note:**

1. Covered Expenses rendered by a non-Tier 1 or Tier 2 provider will be paid at the Tier 1 level (not subject to usual and customary limits) if the Covered Person is a student attending school outside the service area, except in the case of elective surgery, or routine visits or checkups.
2. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level.
3. For questions about services not provided at St. Luke's please contact the Benefits Office.

Revised 10/2023

# St. Luke's Hospital

## Premium Plan
## 2024 SCHEDULE OF BENEFITS

(This Summary of Benefits provides a simplified overview of the medical plan. The plan is governed by the terms of legal documents. We have taken care to ensure that the following are accurate. However, if there is a conflict between this Summary of Benefits chart and the legal documents, the legal documents will be followed.)

| **DESCRIPTION OF MEDICAL BENEFITS – Premium Plan** | **ST. LUKE'S NETWORK** Tier 1 | **UNITED HEALTHCARE NETWORK** Tier 2 | **OUT OF NETWORK** Tier 3 |
|---|---|---|---|
| **Calendar Year Deductible**<br>• Individual | $200 | $600 | $1,500 |
| • Family | $450 | $1,500 | $2,200 |
| **Calendar Year Out-of-Pocket Maximum (Includes deductible amount listed above)**<br>• Individual | $1,250 | $3,700 | $6,325 |
| • Family | $2,000 | 7,000 | $11,360 |
| **Pre-Certification Requirements***<br>• Inpatient<br>o Elective admissions must be pre-certified prior to any elective admission to a Hospital, Hospice Facility, Residential Treatment Facility or Skilled Nursing Facility, or within 2 working days for emergency admissions.<br>o A $500 deductible for each period of confinement may be imposed for failure to pre-certify inpatient confinements. This deductible does not apply to the Out-of-Pocket Maximum.<br>• Treatment Plan Certification<br>o Treatment plans may be required for some services (i.e., Chemotherapy) in order to determine length and type of service for payment purposes.<br>• Additional Care Requiring Precertification<br>o Clinical Trials<br>o Spinal/Back Surgery for Tier 2 and Tier 3<br>o Pain Management including injectables for Tier 2 and Tier 3<br><br>***All plan options may require pre-certification, pre-determination, preauthorization, treatment plan information, or a letter of medical necessity depending upon the specific medical treatment or procedure. You may contact UMR at 1-800-826-9781 for specific information.** | | | |
| **Hospital / Facility Services**<br>• Inpatient | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Outpatient – CT Scan, MRI and PET Scan | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Emergency Room Services**<br>Only Medical Emergencies as defined by the Plan are covered. Copay waived if patient is admitted as an Inpatient, then Inpatient benefits apply | $250 copay<br>then 100%<br>No deductible | $250 copay<br>then 100%<br>No deductible | $250 copay<br>then 100%<br>No deductible |

| **DESCRIPTION OF MEDICAL BENEFITS – Premium Plan** | **ST. LUKE'S NETWORK** Tier 1 | **UNITED HEALTHCARE NETWORK** Tier 2 | **OUT OF NETWORK** Tier 3 |
|---|---|---|---|
| **Urgent Care Facility** | $20 copay<br>then 100%<br>No deductible | $35 copay<br>then 100%<br>No deductible | 60%<br>After deductible |
| **Pre-Admission Testing** | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Outpatient Surgery**<br>At Hospital or Ambulatory Surgical Center<br>• Facility | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Surgeon and Anesthesiologist<br>• Pathologist and Radiologist | 90%<br>After Tier 1 deductible | | 60%<br>After deductible |
| **Voluntary Second Surgical Opinion**<br>• Primary Care Physician | $10 copay 100% No deductible | | 60%<br>After deductible |
| • Specialist | $15 copay 100% No deductible | | 60%<br>After deductible |
| **Physician Office Services –**<br>All services performed in the Physician's office including:<br>• Office visits or Telehealth visits<br>• Surgical procedures<br>• Laboratory and x-ray (test obtained and processed in office only)<br>• Eye Exam, limited to **1 per calendar year**<br>• Allergy injections<br>• Allergy testing<br>• Chemotherapy administration, injectables, medications, casts, and other treatment materials (see Pre-cert requirements).<br>- Primary Care Physician | $10 copay for office visit<br>$0 copay for telehealth visit<br>then 100% No deductible | | 60%<br>After deductible |
| - Specialist | $15 copay for office visit<br>$0 copay for telehealth visit<br>then 100% No deductible | | 60%<br>After deductible |
| **Physician Services Other – Inpatient or Outpatient**<br>• Surgeon and Assistant Surgeon<br>• Anesthesiologist, Radiologist and Pathologist – services rendered by a Tier 3 Anesthesiologist, Radiologist or Pathologist at a Tier 1 or Tier 2 facility will be paid at the higher coinsurance level of the facility. | 90%<br>After Tier 1 deductible | | 60%<br>After deductible |
| **Labs Performed Outside Physician Office – Diagnostic** | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| Wellness Care<br>• Preventative/Routine adult office visit (18yrs+), including diabetes screening, routine lab and x-ray, counseling and screening for HIV, as necessary to obtain covered preventative services, **1 per calendar year** (all appropriate immunizations per UMR guidelines)<br>- Facility | 100%<br>No deductible | | 60%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Premium Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| • Well woman gynecological exams and pap smear, including routine lab processing, as necessary to obtain covered preventative services<br>• Obstetrical Care, as necessary to obtain specified preventative services including routine prenatal visits, tobacco cessation counseling and immunizations (note: this does not include delivery or high risk maternity services)<br>• Screening and counseling for STD's and domestic violence<br>• HPV testing and counseling (30yrs+ 1 every 3 years)<br>• 2 ultrasounds covered at 100% of allowable, gestational diabetes screening (2 per pregnancy)<br>• Approved contraceptive methods, including sterilization<br>• Breastfeeding supplies, counseling and support, including rental of breast pump. Covers purchase of non-hospital grade breast pump or new supplies for existing pump (1 per pregnancy)<br>- Facility | 100%<br>No deductible | | 60%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Mammograms<br>- Facility | 100%<br>No deductible | | .<br>60%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Colonoscopy, limited to 1 routine test every 10 years starting at age 45. Includes anesthesia<br>- Facility | 100%<br>No deductible | | 60%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Well man PSA, including routine lab, limited to 1 per calendar year.<br>- Facility | 100%<br>No deductible | | 60%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Well baby care/pediatric exams (up to age 18), including all appropriate immunizations per UMR guidelines, lab and x-ray. (Note: annual school physicals are not covered.)<br>- Facility | 100%<br>No deductible | | 50%<br>No deductible |
| - Primary Care Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Other preventative/routine care as required under the Women's Preventative Services | 100%<br>No deductible | | 60%<br>No deductible |

| DESCRIPTION OF MEDICAL BENEFITS – Premium Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Mental/Nervous Disorders (including autism spectrum disorder care and applied behavior analysis programs)**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 90%<br>After Tier 1 deductible | | 60%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | $10 copay<br>100% No deductible | | 60%<br>After deductible |
| - Specialist | $15 copay<br>100% No deductible | | 60%<br>After deductible |
| **Alcoholism and Drug Abuse**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 90%<br>After Tier 1 deductible | | 60%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | $10 copay<br>100% No deductible | | 60%<br>After deductible |
| - Specialist | $15 copay<br>100% No deductible | | 60%<br>After deductible |
| **Skilled Nursing Facility**<br>All stays are pre-certified for medical necessity. | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Clinical Trials**<br>• Includes services typically provided for other conditions<br>• *Excludes investigational items or devices, data collection costs or services outside established standards of care. | 85%<br>After deductible* | 75%<br>After deductible* | 60%<br>After deductible* |
| **Home Health Care**<br>Must be within 14 days of a Hospital or Skilled Nursing Facility confinement, with a maximum of 90 visits (in combination with Outpatient Hospice Care) in a 12-month period. (Excludes custodial care). | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Hospice Care Services**<br>• Inpatient (See pre-certification requirements) | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Outpatient | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Private Duty Nursing**<br>$5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care).<br>• Inpatient | 90%<br>After Tier 2 deductible | | 50%<br>After deductible |
| • Outpatient | 90%<br>After Tier 2 deductible | | 50%<br>After deductible |
| **Maternity**<br>Female Employees and Dependents | Same as any other Illness | | |
| **Newborn**<br>Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren). | Same as any other Illness | | |
| **Ambulance Services** | 90%<br>After Tier 1 deductible | | |

| DESCRIPTION OF MEDICAL BENEFITS – Premium Plan | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Physical Therapy**<br>Maximum of 60 visits in combination with occupational therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Physician<br>- Primary Care Physician | $10 copay-100%<br>No deductible | $20 copay-100%<br>No deductible | 60%<br>After deductible |
| - Specialist | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 60%<br>After deductible |
| **Occupational Therapy**<br>Maximum of 60 visits in combination with physical therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Physician<br>- Primary care Physician | $10 copay-100%<br>No deductible | $20 copay-100%<br>No deductible | 60%<br>After deductible |
| - Specialist | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 60%<br>After deductible |
| **Speech Therapy**<br>Maximum of 60 visits in combination with physical therapy and occupational therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Physician<br>- Primary Care Physician | $10 copay-100%<br>No deductible | $20 copay-100%<br>No deductible | 60%<br>After deductible |
| - Specialist | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 60%<br>After deductible |
| **Habilitation Services** | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| **Inhalation Therapy and Radiation Therapy**<br>• Facility | 90%<br>After deductible | 75%<br>After deductible | 60%<br>After deductible |
| • Physician<br>- Primary Care Physician | $10 copay-100%<br>No deductible | $20 copay-100%<br>No deductible | 60%<br>After deductible |
| - Specialist | $15 copay-100%<br>No deductible | $30 copay-100%<br>No deductible | 60%<br>After deductible |
| **Transplant Services:**<br>- Physician<br>- Facility – Designated Transplant Centers of Excellence | 90%<br>After Tier 1 deductible | | Not Covered |
| **Transplant Services:**<br>- Travel and housing<br>Maximum Benefit per transplant | $10,000 | | Not Covered |

| DESCRIPTION OF MEDICAL BENEFITS – Premium | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Durable Medical Equipment – Charges over $500 must be pre-certified.** | 85% After Tier 2 deductible | | 60% After deductible |
| **Artificial Limbs/Prosthesis** | 90% After Tier 2 deductible | | 60% After deductible |
| **Chiropractic Care: Maximum of 20 visits. (Such visit limit does not apply when chiropractic care is coded as a mental health or substance use disorder service.)** | $25 copay after deductible | $30 copay after deductible | Not covered |
| **All Other Covered Facility Charges** | 90% After deductible | 85% After deductible | 60% After deductible |
| **All Other Covered Physician Charges** | 90% After Tier 1 deductible | | 60% After deductible |
| **Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders** | 90% After Tier 1 deductible | | 60% After deductible |

| Pharmacy Benefits | | |
|---|---|---|
| **Prescription Drugs The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office. (*Refer to Appendix Section D for additional information)*** | **Tier 1 & Tier 2-3 First Fills (Copay)** | **Tier 2 – 3 Refills (Copay)** |
| • Retail – (Prescriptions refilled at Tier 1 network will be discounted). | Generic - $10.00<br>Preferred - $25.00<br>Non–Preferred - $50.00 | Generic - $15.00<br>Preferred - $30.00<br>Non-Preferred - $75.00 |
| • Specialty Rx/30-day All specialty prescriptions must be filled through Capital Rx or at St. Luke's Hospital pharmacy | **Copay $150.00** | |
| • Mail Order / 90-day<br>Generic<br>Preferred Brand<br>Non-Preferred Brand | <br>$20.00 copay<br>$50.00 copay<br>$100.00 copay | <br>$30.00 copay<br>$67.50 copay<br>$187.00 copay |

**Note:**

1. Covered Expenses rendered by a non-Tier 1 or Tier 2 provider will be paid at the Tier 1 level (not subject to usual and customary limits) if the Covered Person is a student attending school outside the service area, except in the case of elective surgery, or routine visits or checkups.
2. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level.
3. For questions about services not provided at St. Luke's Hospital please contact the Benefits Office.

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# St. Luke's Hospital

## High Deductible Health Plan
## 2024 SCHEDULE OF BENEFITS

(This Summary of Benefits provides a simplified overview of the medical plan. The plan is governed by the terms of legal documents. We have taken care to ensure that the following are accurate. However, if there is a conflict between this Summary of Benefits and the legal documents, the legal documents will be followed.)

| DESCRIPTION OF MEDICAL BENEFITS - HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Calendar Year Deductible (Medical & Pharmacy)** | | | |
| • Individual Coverage (Employee Only Plan) | $1,700 | $3,800 | $4,500 |
| • Family Coverage | $3,200 | $6,000 | $7,400 |
| **Health Savings Account /St. Luke's Contribution** | | | |
| • **Individual** | $500 | | |
| • **Family** | $1000 | | |
| **Calendar Year Out-of-Pocket Maximum (Includes deductible amounts listed above)** | | | |
| • Individual- must pay deductible expense in the calendar year equal to the Individual Deductible before medical and pharmacy benefits are paid. | $1,900 | $5,500 | $6,700 |
| • Family- Members of an enrolled family must pay deductible expense in the calendar year equal to the Family Deductible before medical and pharmacy benefits are paid. | $3,800 | $10,000 | $12,400 |
| **Pre-Certification Requirements*** | | | |
| • Inpatient | | | |
| o Elective admissions must be pre-certified prior to any elective admission to a Hospital, Hospice Facility, Residential Treatment Facility or Skilled Nursing Facility, or within 2 working days for emergency admissions. | | | |
| o A $500 deductible for each period of confinement may be imposed for failure to pre-certify inpatient confinements. This deductible does not apply to the Out-of-Pocket Maximum. | | | |
| • Treatment Plan Certification | | | |
| o Treatment plans may be required for some services (i.e., Chemotherapy) in order to determine length and type of service for payment purposes. | | | |
| • Additional Care Requiring Precertification | | | |
| o Clinical Trials | | | |
| o Spinal / Back Surgery for Tier 2 and Tier 3 | | | |
| o Pain Management including injectables for Tier 2 and Tier 3 | | | |
| ***All plan options may require pre-certification, pre-determination, preauthorization, treatment plan information, or a letter of medical necessity depending upon the specific medical treatment or procedure. You may contact UMR at 1-800-826-9781 for specific information.** | | | |
| **Hospital / Facility Services** | 90% | 80% | 70% |
| • Inpatient | after deductible | After deductible | After deductible |
| • Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services | 90% After deductible | 80% After deductible | 70% After deductible |
| • Outpatient – CT Scan, MRI and PET Scan | 90% After deductible | 80% After deductible | 70% After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Emergency Room Services**<br>Only Medical Emergencies as defined by the Plan are covered. Copay waived if patient is admitted as an Inpatient, then Inpatient benefits apply | 90%<br>After Tier 1 deductible | 90%<br>After Tier 1 deductible | 90%<br>After Tier 1 deductible |
| **Urgent Care Facility** | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **Pre-Admission Testing** | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **Outpatient Surgery**<br>At Hospital or Ambulatory Surgical Center<br>• Facility | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Surgeon and Anesthesiologist<br>• Pathologist and Radiologist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Voluntary Second Surgical Opinion**<br>• Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| • Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Physician Office Services –**<br>All services performed in the Physician's office including:<br>• Office visits<br>• Surgical procedures<br>• Laboratory and x-ray (test obtained and processed in office only)<br>• Eye Exam, limited to **1 per calendar year**<br>• Allergy injections<br>• Allergy testing<br>• Chemotherapy administration, injectables, medications, casts, and other treatment materials (see Pre-cert requirements).<br>- Primary Care Physician | 90% for office visit<br>100% for telehealth visit<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90% for office visit<br>100% for telehealth visit<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Physician Services Other – Inpatient or Outpatient**<br>• Surgeon and Assistant Surgeon<br>• Anesthesiologist, Radiologist and Pathologist – services rendered by a Tier 3 Anesthesiologist, Radiologist or Pathologist at a Tier 1 or Tier 2 facility will be paid at the higher coinsurance level of the facility. | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Labs Performed Outside Physician Office – Diagnostic** | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Wellness Care**<br>• Preventative/Routine adult office visit (18yrs+), including diabetes screening, routine lab and x-ray, counseling and screening for HIV, as necessary to obtain covered preventative services, **1 per calendar year** (all appropriate immunizations per UMR guidelines)<br>- Facility | 100%<br>No deductible | | 70%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>After deductible |
| • Well woman gynecological exams and pap smear, including routine lab processing, as necessary to obtain covered preventative services<br>• Obstetrical Care, as necessary to obtain specified preventative services including routine prenatal visits, tobacco cessation counseling and immunizations (note: this does not include delivery or high risk maternity services)<br>• Screening and counseling for STD's and domestic violence<br>• HPV testing and counseling (30yrs+ 1 every 3 years)<br>• 2 ultrasounds covered at 100% of allowable, gestational diabetes screening (2 per pregnancy)<br>• Approved contraceptive methods, including sterilization<br>• Breastfeeding supplies, counseling and support, including rental of breast pump. Covers purchase of non-hospital grade breast pump or new supplies for existing pump (1 per pregnancy)<br>- Facility | 100%<br>No deductible | | 70%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Mammograms<br>- Facility | 100%<br>No deductible | | 70%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Colonoscopy limited to 1 routine test every 10 years starting at age 45. Includes anesthesia<br>- Facility | 100%<br>No deductible | | 70%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Well man PSA, including routine lab, limited to **1 per calendar year.**<br>- Facility | 100%<br>No deductible | | 70%<br>After deductible |
| - Physician | 100%<br>No deductible | | 100%<br>No deductible |

| DESCRIPTION OF MEDICAL BENEFITS – HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| • Well baby care/pediatric exams (up to age 18), including all appropriate immunizations per UMR guidelines, lab and x-ray. (Note: annual school physicals are not covered.)<br>- Facility | 100%<br>No deductible | | 70%<br>No deductible |
| - Primary Care Physician | 100%<br>No deductible | | 100%<br>No deductible |
| • Other preventative/routine care as required under the Women's Preventative Services | 100%<br>No deductible | | 70%<br>After deductible |
| **Mental/Nervous Disorders (including autism spectrum disorder care and applied behavior analysis programs)**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Alcoholism and Drug Abuse**<br>• Inpatient Treatment<br>- Partial/Day program<br>- Residential Treatment Facility | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| • Outpatient Treatment<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Skilled Nursing Facility**<br>All stays are pre-certified for medical necessity. | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **Clinical Trials**<br>• Includes services typically provided for other conditions<br>• *Excludes investigational items or devices, data collection costs or services outside established standards of care. | 90%<br>After deductible* | 80%<br>After deductible* | 70%<br>After deductible* |
| **Home Health Care**<br>Must be within 14 days of a Hospital or Skilled Nursing Facility confinement, with a maximum of 90 visits (in combination with Outpatient Hospice Care) in a 12-month period. (Excludes custodial care). | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **Hospice Care Services**<br>• Inpatient (See pre-certification requirements) | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Outpatient | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **Private Duty Nursing**<br>$5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care).<br>• Inpatient | 50%<br>After deductible | 50%<br>After deductible | 50%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Private Duty Nursing (Continued)**<br>• Outpatient | 90%<br>After deductible | 90%<br>After deductible | 50%<br>After deductible |
| **Maternity**<br>Female Employees and Dependents | Same as any other Illness | | |
| **Newborn**<br>Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren). | Same as any other Illness | | |
| **Ambulance Services** | 90%<br>After Tier 1 deductible | | |
| **Physical Therapy**<br>Maximum of 60 visits in combination with occupational therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Physician<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Occupational Therapy**<br>Maximum of 60 visits in combination with physical therapy and speech therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Physician<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Speech Therapy**<br>Maximum of 60 visits in combination with physical therapy and occupational therapy. (Such visit limit does not apply when therapy is coded as a mental health or substance use disorder service.)<br>• Facility | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Physician<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Habilitation Services** | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |

| DESCRIPTION OF MEDICAL BENEFITS – HDHP | ST. LUKE'S NETWORK Tier 1 | UNITED HEALTHCARE NETWORK Tier 2 | OUT OF NETWORK Tier 3 |
|---|---|---|---|
| **Inhalation Therapy and Radiation Therapy**<br>• Facility | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| • Physician<br>- Primary Care Physician | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| - Specialist | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Transplant Services:**<br>- Physician<br>- Facility – Designated Transplant Centers of Excellence | 90%<br>After Tier 2 deductible | | Not Covered |
| **Transplant Services:**<br>- Travel and housing Maximum Benefit per transplant | $10,000 | | Not Covered |
| **Durable Medical Equipment – Charges over $500 must be pre-certified.** | 80%<br>After Tier 2 deductible | | 70%<br>After deductible |
| **Artificial Limbs/Prosthesis** | 80%<br>After Tier 2 deductible | | 70%<br>After deductible |
| **Chiropractic Care:**<br>**Maximum of 20 visits. (Such visit limit does not apply when chiropractic care is coded as a mental health or substance use disorder service.)** | 90% after Tier 1 deductible | 80% after Tier 2 deductible | Not covered |
| **All Other Covered Facility Charges** | 90%<br>After deductible | 80%<br>After deductible | 70%<br>After deductible |
| **All Other Covered Physician Charges** | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |
| **Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders** | 90%<br>After Tier 1 deductible | | 70%<br>After deductible |

| Pharmacy Benefits | | | |
|---|---|---|---|
| **Prescription Drugs: The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts applicable to your elected coverage option. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office. (*Refer to Appendix Section D for additional information)*** <br>• **Retail – 30 Day** <br>Generic <br>Preferred Brand <br>Non-Preferred Brand | Tier 1<br><br>After calendar year deductible is met 10% Co-insurance will apply until Out of Pocket Maximum is met | Tier 2 - 3<br><br>After calendar year deductible is met 20% Co-insurance will apply until Out of Pocket Maximum is met | Tier 2 - 3<br><br>After calendar year deductible is met 20% Co-insurance will apply until Out of Pocket Maximum is met |
| • **Specialty Tier** – 30 Day All specialty prescriptions must be filled through Capital Rx or at St. Luke's Hospital pharmacy | After calendar year deductible is met 10% Co-insurance will apply until Out of Pocket Maximum is met | After calendar year deductible is met 20% Co-insurance will apply until Out of Pocket Maximum is met | N/A |
| • **Mail Order – 90 Day** <br>Generic <br>Preferred Brand <br>Non-Preferred Brand | After calendar year deductible is met 10% Co-insurance will apply until Out of Pocket Maximum is met | After calendar year deductible is met 20% Co-insurance will apply until Out of Pocket Maximum is met | Capital Rx Pharmacy Network<br><br>After calendar year deductible is met 20% Co-insurance will apply until Out of Pocket Maximum is met |
| **Note:** 1. Covered Expenses rendered by a non-Tier 1 or Tier 2 provider will be paid at the Tier 1 level (not subject to usual and customary limits) if the Covered Person is a student attending school outside the service area, except in the case of elective surgery, or routine visits or checkups. <br>2. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level. <br>3. For questions about services not provided at St. Luke's please contact the Benefits Office. <br>4. You are eligible to participate in a Health Savings Account (HSA) if you enroll in the HDHP | | | |

Revised 10/2023

**What's Not Covered:**

Here are examples of charges / services that will not be covered under medical coverage:

- Cosmetic or re-constructive surgery;
- Custom molded foot orthotic;
- Any charges for a job-related (payment rendered) injury, or as a result of an injury due to war, whether declared or undeclared;
- Services, including transplants, which are experimental, investigational or educational in nature;
- Services provided by a family member of the employee or any covered dependents, including but not limited to the employee, or covered dependent, or a participant's spouse, sibling, parent or child, even if the individual is a participating provider;
- Charges incurred prior to the effective date of coverage or after termination of coverage;
- Charges for failure to keep a scheduled appointment;
- Charges in excess of the customary rate;
- Infertility Treatment;
- Some types of genetic testing;
- Kerato-refractive eye surgery, including but not limited to, radial keratotomy, keratomileusis surgery, and Lasik;
- Hearing aids;
- Treatment for Temporomandibular Joint (TMJ) Syndrome, including appliances;
- Wilderness therapy; or
- Weight loss medication

**This list is not all-inclusive – please contact UMR 1-800-826-9781 for more specific questions related to coverage.**

**What is Not Covered during an Emergency Room Visit:***

- Bronchitis
- Chronic Rhinitis
- Conjunctivitis
- Dental issues/tooth pain
- Earaches
- Upper Respiratory Infections

For all non-emergent needs, please contact your primary care physician's office; visit one of our Urgent Care Centers. * Applies to covered members age 6 and older.

# Dental Benefits

Dental coverage helps you pay for most dental expenses and encourages you and your family to receive preventive dental care. St. Luke's offers a Basic Plan and a Premium Option for employees interested in Dental coverage.

**Your Options**

1. Basic Plan
2. Premium Plan
3. Decline coverage

**Basic Plan Option**
The Basic Option has a higher deductible and lower coinsurance than the Premium Option, so it will cost you more when you go the dentist. Because the coverage level is not as high, the Basic Option has lower premiums.

**Premium Plan Option**
The Premium Option has a lower deductible and a higher coinsurance than the Basic Option, so you pay less out of pocket when you receive care. The Premium Option also offers a higher annual maximum and higher Orthodontia Lifetime Limit. Since this option offers a higher level of benefits than the Basic Option, it costs more.

**Your Dental Options**

| | **Basic Plan*** | **Premium Plan*** |
|---|---|---|
| Network | None | None |
| Deductible | $75 Individual / $225 Family | $50 Individual / $150 Family |
| Diagnostic / Preventive Services | 100%* Not subject to deductible | 100%* Not subject to deductible |
| Basic Restorative | 60% After deductible | 80% After deductible |
| Major Restorative | 40% After deductible | 50% After deductible |
| Annual Maximum Benefit (per person/year) | $1,000 | $2,500 |
| Orthodontia | 50% | 50% |
| Orthodontia Lifetime Maximum | $1,000 | $2,000 |

*Covers 100% of usual and customary charges. Plan will not cover billed amounts over usual and customary rates, and patient is responsible for these amounts.

**Under the Basic and Premium Dental plans you may choose any dentist you wish. However, you receive the most advantageous pricing if you select a dentist from the** United Healthcare Dental PPO
Finding an in-network dentist

- Call the toll-free number listed on the back of your UMR ID card-**1-800-826-9781**
- Visit WWW.umr.com on your computer or mobile device.
- Select **Find a provider** from the home page
- Choose **Dental**
- Type **UnitedHealthcare Dental PPO** in the search box or use the alphabetical listing

**Dental care is an important part of your well-being**

- Dental insurance helps you to reduce costs for routine dental care and unexpected dental expenses.

- You generally pay less for services when you visit in-network dentists because the percentages you pay for the care you receive are based on discounted rates.

- Participating dentists may also offer negotiated rates on additional services such as tooth whitening.*

- United Healthcare Dental PPO Administrators program includes a network of dentists that are located all over the country, so it's likely you'll be able to find participating dentists no matter where you live.

**A broad dental network to help save you money**

- The United Healthcare Dental PPO Administrators program has a large network of dentists.

**Network includes general dentists and specialists**

- You can check the availability of a general dentist or specialist in your area by accessing the provider network online. The directory is updated regularly.

**Dentists are screened to meet network requirements**

- Before acceptance into the United Healthcare Dental PPO Administrators program, prospective dentists must successfully complete a credentialing process. They are credentialed in accordance with state law requirements.

**Finding a dentist near you is easy. Use our online directory:**

- **umr.com**

**Pre-determination of Benefits:**

If a charge of a dental care provider for a proposed course of treatment is expected to cost $300 or more, a description from the dental care provider, detailing charges should be submitted along with a treatment plan to UMR prior to the commencement of services to appropriately determine coverage allowances.

**How Dental Coverage Works for the Basic and Premium Dental Plans**

**Diagnostic / Preventive Services**

- Routine oral examinations, routine prophylaxis (cleaning of teeth), twice in any 12-month period performed 6 months apart.
- Two topical applications of fluoride per year for dependent children up to age 19;
- One full-mouth or panorex X-ray every two years; and two sets of bitewing X-rays per year.
- Space maintainers for post primary teeth and habit breaking appliances.
- Emergency palliative treatment in order to relieve pain when no other dental services are performed, except X-rays, twice in any period of 24 consecutive months.
- Sealants, for dependent children up to age 19.

**Basic Services**

- Amalgam, silicate acrylic, synthetic porcelain or composite fillings restoration;
- Non-surgical extractions;
- Oral surgery not covered under medical benefits;
- Dental examination and X-rays as required in connection with the diagnosis of a specific condition requiring treatment;
- General anesthetics and laboratory procedures when medically necessary and administered in connection with oral or dental surgery;
- Medication when provided by injection in the dentist's office;
- Necessary treatment for relief of pain;
- Endodontics (root canal treatment);
- Denture relines and rebases;
- Consultation by attending specialist; and
- Periodontic (gum disease) treatment, including periodontic surgery.

**Major Services**

- Inlays, onlays, gold fillings or crown restoration, but only when the tooth cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration;
- Periodontal examination and other periodontal treatments, including gingival curettage, gingivectomy, gingivoplasty and osseous surgery. These are all procedures for the treatment of the gums or the bony structures of the mouth that support the teeth.
- Initial installation of fixed bridgework, including inlays and onlays as abutments;
- Initial installation of partial or full removable dentures; and
- Replacement of an existing denture or fixed bridgework or the addition of teeth to an existing partial removable denture or bridgework, but only if satisfactory evidence is presented that:
    - The replacement or addition of teeth is required to replace one or more teeth extracted after the patient is covered by the plan;

- The existing denture or bridgework cannot be made serviceable, is at least five years old and is replaced two or more years after the patient is covered under the plan;
- The existing denture is an immediate temporary denture installed after the effective date of dental coverage and replacement by a permanent denture takes place within 12 months; and
- The replacement denture or bridgework is made necessary as the result of an accident while covered and is installed within 12 months after such injury.

**Orthodontic Services**

- Orthodontic diagnostic procedures, including X-rays;
- Surgical therapy and procedures for straightening the teeth; and
- Appliances to realign the teeth, including Invisalign.

**What's Not Covered**

The following list includes, but is not limited to, those charges that will not be covered under the dental plan:

- Orthodontic services when the bands are already in place, charges for invisible aligners or clear aligner or if first phase of treatment plan has happened prior to your enrollment.
- You cannot switch from the Basic Option to the Premium Option to receive the higher lifetime maximum once treatment has begun;
- Any charges incurred for a job-related (payment rendered) injury due to war, whether declared or undeclared.
- The replacement of teeth that were missing before your coverage becomes effective;
- Charges for failure to keep a scheduled appointment;
- Treatment by someone other than a licensed dentist, physician or qualified dental technician under the direction of a dentist or physician;
- Implants or experimental treatment;
- Cosmetic services and supplies that are provided mainly to improve appearance;
- Replacement of dentures that have been lost, mislaid or stolen;
- Treatment of temporomandibular joint syndrome (TMJ), change vertical dimension, stabilize periodontally involved teeth, and/or restore occlusion;
- Services provided by a family member of the employee or any covered dependents, including but not limited to the employee or covered dependent, or a participant's spouse, sibling, parent, child or grandchild, even if the individual is a participating provider;
- Services provided or supplies received while you or your dependent are not covered by the plan;
- Charges in excess of the customary rate; or
- Charges for completion of insurance forms.

Procedures, appliances or restorations (other than dentures), including:

- Charges incurred in connection with any injury sustained while an individual is engaged in any criminal enterprise or illegal activity.

# Vision Benefits

St. Luke's offers a choice of vision plans through VSP to help you manage the cost of vision care for you and your family.

# A Look at Your VSP Vision Coverage

**With VSP and ST. LUKE'S HOSPITAL, your health comes first.**

**Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.**

vsp vision care | St. Luke's HOSPITAL | St. Luke's Des Peres HOSPITAL

### Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

### Provider choices you want.

Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

### Quality vision care you need.

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

### Using your benefit is easy!

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

| | WITHOUT VSP | WITH VSP COVERAGE |
|---|---|---|
| Eye Exam | $181 | $10 |
| Frame | $130 | $25 |
| Bifocal Lenses | $147 | |
| Custom Progressive Lenses | $254 | $150 |
| Anti-glare Coating | $149 | $85 |
| Member-only Annual Contribution | N/A | $63.36 |
| Total | $861 | $333.36 |

Based on state and national averages for eye exams and most commonly purchased brands. This chart represents average savings for VSP members. Your actual savings will depend on the eyewear you choose, the plan available to you, your copays, your premium, and whether it is deducted from your paycheck pre-tax.

**YOUR ESTIMATED ANNUAL SAVINGS WITH VSP**

**$527.64**

Enroll through your employer today.

Contact us: **800.877.7195** or **vsp.com**

# Your VSP Vision Benefits Summary

New for 2023, ST. LUKE'S HOSPITAL and VSP have teamed up to provide you with a choice of affordable vision plans. Choose the eye care essentials, or upgrade to give your eyes extra love.

**PROVIDER NETWORK:**
VSP Choice

**EFFECTIVE DATE:**
01/01/2023

vsp vision care

| BENEFIT | DESCRIPTION | COPAY |
|---|---|---|
| **BASE plan** Coverage with a VSP Provider | | |
| **WELLVISION EXAM** | • Focuses on your eyes and overall wellness<br>• Every calendar year | $10 |
| **ESSENTIAL MEDICAL EYE CARE** | • Retinal screening for members with diabetes<br>• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.<br>• Coordination with your medical coverage may apply. Ask your VSP doctor for details.<br>• Available as needed | $0 per screening<br>$20 per exam |
| **PRESCRIPTION GLASSES** | | **$25** |
| **FRAME**+ | • $180 featured frame brands allowance<br>• $130 frame allowance<br>• 20% savings on the amount over your allowance<br>• $130 Walmart® frame allowance<br>• $70 Costco® frame allowance<br>• Every other calendar year | Included in Prescription Glasses |
| **LENSES** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children<br>• Every calendar year | Included in Prescription Glasses |
| **LENS ENHANCEMENTS** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 30% on other lens enhancements<br>• Every calendar year | $0<br>$95 - $105<br>$150 - $175 |
| **CONTACTS (INSTEAD OF GLASSES)** | • $130 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation)<br>• Every calendar year | Up to $60 |

| BENEFIT | DESCRIPTION | COPAY |
|---|---|---|
| **PREMIUM plan** Coverage with a VSP Provider | | |
| **WELLVISION EXAM** | • Focuses on your eyes and overall wellness<br>• Every calendar year | $5 |
| **ESSENTIAL MEDICAL EYE CARE** | • Retinal screening for members with diabetes<br>• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.<br>• Coordination with your medical coverage may apply. Ask your VSP doctor for details.<br>• Available as needed | $0 per screening<br>$20 per exam |
| **PRESCRIPTION GLASSES** | | **$10** |
| **FRAME**+ | • $250 featured frame brands allowance<br>• $200 frame allowance<br>• 20% savings on the amount over your allowance<br>• $200 Walmart® frame allowance<br>• $110 Costco® frame allowance<br>• Every calendar year | Included in Prescription Glasses |
| **LENSES** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children<br>• Every calendar year | Included in Prescription Glasses |
| **LENS ENHANCEMENTS** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 30% on other lens enhancements<br>• Every calendar year | $0<br>$95 - $105<br>$150 - $175 |
| **CONTACTS (INSTEAD OF GLASSES)** | • $200 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation)<br>• Every calendar year | Up to $60 |

| | |
|---|---|
| **EXTRA SAVINGS** | **Glasses and Sunglasses**<br>• Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details.<br>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. |
| | **Routine Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam |
| | **Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities |

**YOUR COVERAGE GOES FURTHER IN-NETWORK**

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

# Continuation of Coverage

If you or your covered dependent(s) become ineligible for group health coverage, you may be able to continue medical, dental or vision coverage for a period of time.

Continuation of coverage is available only if you or your dependents had coverage under the active plan immediately prior to the qualifying event date (the date you or your dependent lost coverage under the active plan). Please contact Human Resources if you're unsure about whether you or your covered dependents can elect continuation coverage.

Continuation benefits only allow you to continue coverage that already was in place. This benefit does not qualify you to add coverage or change plans. For example, if you had Basic Medical and go on continuation of coverage, you are not eligible to add Dental coverage or change to the Premium Medical Plan.

| If You: | Who Can Continue | For How Long: |
|---|---|---|
| Terminate your employment with St. Luke's | You, your spouse or your dependent(s) | Up to 18 months |
| Are no longer eligible to be covered under the active plan | You, your spouse or your dependent(s) | Up to 18 months |
| Are eligible for Medicare | Your spouse or dependent(s) | Up to 36 months |
| Divorce | Your ex-spouse | Up to 36 months |
| Die | Your spouse, or dependent(s) | Up to 36 months |

**Important Note:**
It is your responsibility to notify the Human Resources Department when your dependent is no longer eligible for coverage.

| If Your Dependent: | Who Can Continue | For How Long: |
|---|---|---|
| No longer meets the definition of an eligible dependent due to divorce | Your dependent(s) | Up to 36 months |
| No longer meets the eligibility requirements | Not eligible to continue | Not eligible |

**When Coverage Ends**
Continuation of coverage ends:

- When you fail to pay the premiums when due;
- At the end of the 18-, 29-, or 36-month period (whichever applies);
- When you become eligible for Medicare;
- When you are covered under another group plan; or
- When you no longer meet the eligibility requirements.
- When you discontinue coverage, you may not re-enroll.

If you wish to continue your coverage, you must enroll through the Benefits Office within 60 days of the qualifying event. Premiums must be paid back to your date of separation.

**Special Provision If You Become Disabled**
If you or your covered dependent becomes Social Security-disabled during the first 60 days of continuation coverage, and the disability is certified within the first 18 months, you or your covered dependent(s) may continue coverage up to 29 months from the original continuation effective date. ***Please note***: You must notify the Benefits Office of the disability certification before the end of 18-month period. (Refer to Appendix Section E for more information.

# Life Insurance

**Term Life Insurance**

St. Luke's offers a choice of term life insurance coverage that can provide security and protection if you or your dependent dies while you are employed.

- **Basic Life** - You automatically receive basic life insurance entirely paid for by St. Luke's based on your employment status. Your coverage begins immediately.

- **Accidental Death and Dismemberment (AD&D)** - You automatically receive AD&D insurance entirely paid for by St. Luke's based on your employment status. Your coverage is an additional one times your basic life insurance amount.

- **Supplemental Life** - You may choose to purchase additional term life insurance to provide extra financial assistance for your family if you die. You pay the cost of this coverage.

- **Dependent Life -** You may purchase dependent life insurance to provide financial assistance if one of your dependents die. You may cover your spouse or your dependent child until age 26 if he or she meets the definition of a dependent under UNUM Life's Plan, at which time coverage ends. You pay for the cost of this coverage. If you and your spouse are both employed by St. Luke's, only one family member can elect supplemental coverage for their spouse or dependents.

## Your Life Insurance Options

Your options depend on the type of insurance and your employment status.

| If You are A: | Basic Life | Supplemental Life Increments | Dependent Life |
|---|---|---|---|
| Full-time Employee | One times your base salary* | 1. One times base salary<br>2. Two times base salary<br>3. Three times base salary<br>4. Four times base salary+<br>5. No coverage | 1. $20,000 spouse / $10,000 per dependent<br>2. $5,000 spouse / $2,500 per dependent<br>3. No coverage |
| Part-time Employee | $5,000 | 1. $10,000<br>2. $20,000<br>3. $30,000<br>4. $40,000<br>5. No coverage | 1. $20,000 spouse / $10,000 per dependent<br>2. $5,000 spouse / $2,500 per dependent<br>3. No coverage |

*Base salary is determined by multiplying your base hourly rate by 2,080 for a 1.0 FTE or by 1,872 for a .9 FTE. This number is then rounded up to the next $1,000.

***+Subject to medical underwriting approval.***

When you are newly eligible for benefits, you may elect 1-3 times your base salary in Supplemental Life coverage up to the plan limit of $500,000 without providing Evidence of Insurability (EOI). If you elect 4 times your base salary an EOI is required for the 4th increment. You will have to submit the EOI to UNUM for underwriting.

**Open Enrollment:**

During St. Luke's annual open enrollment, if you already have supplemental life insurance, you will be able to increase your coverage by 1 increment up to 3 times your base salary with no EOI required. During open enrollment, EOI is required for:

- Increases of more than 1 increment
- 4 times base salary
- First-time elections during open enrollment

**Status Change:**

Any change to employment status, (example: part-time to full-time or full-time to part-time), requires re-election of your supplemental life insurance benefits. Contact your Benefits department to submit your re-election.

**Life Insurance Limits**

**Basic Life Reduction Beginning at Age 65**

When you reach age 65, your basic and supplemental life coverage is reduced as follows. **Life insurance amount will not increase after age 65. Your life insurance amount at age 65 will remain until your employment ends.**

| At Age: | Coverage is Reduced by: |
|---|---|
| 65 | 35% |
| 70 | 55% |
| 75 | 70% |
| 80 | 80% |

**How Benefits Are Paid**

Life insurance benefits normally are paid to your beneficiary in a lump sum. If you die, the Benefits Office will work with your beneficiary to process the life insurance claim.

If you're terminally ill and not expected to live longer than six months, you may apply to receive 50% of the basic life insurance principal, up to $50,000, in advance. The balance will be paid to your beneficiary upon your death.

**Beneficiary Designation:**
**If you haven't designated a beneficiary or you'd like to change your beneficiary, please designate or make changes in Lawson Employee Self Service module located on the St. Luke's intranet. Please be sure to print a copy of your Beneficiary designation for your records.**

## Business Travel Insurance

St. Luke's provides, at no cost, business travel insurance to all employees. The policy provides protection and security in the event of loss of life or limb while you are traveling on business for St. Luke's.

# Long-Term Disability

If you are a full-time employee, long-term disability (LTD) coverage can replace a portion of your income if you become disabled and can't work for an extended period of time.

**Your Options**

1. Basic - 60% of monthly pay (up to $10,000 per month); or
2. Premium – 66 $^{2}/_{3}$% of monthly pay (up to $10,000 per month)

If you elect Premium LTD, the cost of the LTD option you select is based on your age and your pay, and is deducted from your pay on a pre-tax basis.

***Please note:*** Evidence of insurability is required in order to obtain Premium LTD coverage if you do not enroll during your first 31 days of employment.

**When Coverage Begins**
St. Luke's provides coverage at no cost to you immediately for full-time employees under the Basic LTD plan. If you are not actively at work on the date you become eligible for coverage, you will not become a participant in the LTD plan until you return to active work.

**Pre-Existing Conditions**

The plan does not cover any disability that begins during the first 12 months of coverage under the plan if that disability is caused by a pre-existing condition.

**Receiving Benefits**

You must file an LTD claim with the claims administrator to start the LTD review process. If approved for LTD benefits, the benefit will not begin until you have been totally disabled for 90 days (referred to as the elimination period). Prudential is our administrator; they can be reached at 877-367-7781.

Your benefit will be determined based upon your monthly earnings for the month immediately preceding your date of disability. Monthly earnings, for LTD purposes, includes regular pay and differentials only. It does not include overtime or bonus pay. Your claim may be approved prior to you exhausting your paid time off (ETO/ESB). If this happens, your monthly LTD benefit amount will be offset by the amount of paid time you receive. If you are paying for LTD coverage, any benefits you receive from the plan are taxable as ordinary income because LTD coverage is paid on a pre-tax basis.

**During the First Two Years**

Total disability means being under the regular care of a physician and unable to perform the essential functions of your regular occupation due to injury or illness.

As long as you are totally disabled, you receive monthly benefits according to your coverage level (60% or 66$^{2}/_{3}$% of pay, depending on your coverage, up to a maximum of $10,000 a month). Your monthly benefit is reduced by any other income you or your family may receive, such as:

- Unemployment compensation benefits;
- Disability benefits under any state or federal worker's compensation law or similar law;

- Automobile no-fault wage replacement benefits;
- Primary and family benefits under the Social Security Act, excluding any cost-of-living increases;
- Payments from any employer to the extent that your monthly income benefit and such payments exceed 100% of your pre-disability earnings;
- Any salary continuation payments from an employer;
- Veteran's benefits;
- Retirement benefits (the offset will be determined based on a single life annuity payment); and
- Disability or unemployment benefits under any group insurance, group mortgage or group credit disability plan.

**After Two Years of Benefits**

To continue to receive the maximum benefit after two years, you must be totally disabled.

Totally disabled means being unable to perform any occupation for which you are reasonably suited, based on education, training and experience. (If your disability is due to a mental health or substance abuse condition, you'll be considered totally disabled after two years only if you are receiving Social Security benefits. If you're no longer eligible for Social Security benefits, your LTD benefits will end.)

As long as you're totally disabled (as defined above), you may continue to receive monthly benefits.

In all cases, you must be under the care of a physician. lf your disability is caused to any extent by a mental or substance abuse condition, your physician must be experienced in or trained to evaluate or treat that condition, and you have to be hospitalized.

**Maximum Benefit Period**

| Age at Disability | Benefit Duration |
|---|---|
| Less to age 60 | To age 65 |
| 60 | 60 months |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 or older | 12 months |

# Flexible Spending Accounts (FSA)

The health FSA is not available to anyone who selects the HDHP/HSA option. Flexible spending accounts are a way to pay for certain health care and dependent day care expenses on a tax-free basis. There are two kinds of flexible spending accounts:

- A **medical spending account** can help you pay for medical, dental, vision and certain other health care expenses (but not premiums) that you and your dependents may incur. You can participate in a medical spending account regardless of whether you have St. Luke's benefits coverage.

- A **dependent care spending account** can help you pay for day care expenses for your children under age 13 and qualifying older dependents, including dependent parents.

If you elect a flexible spending account, you contribute to it – before taxes – in equal installments totaling 24 pay periods throughout the year. Your contributions must fall within these annual limits:

| | Annual Minimum | Annual Maximum |
|---|---|---|
| Medical Spending Account | $130 | $3,050 |
| Dependent Care Spending Account | $480 | $5,000 |

You may be reimbursed from your flexible spending account only for eligible expenses that were incurred during the same period in which you enrolled in and made contributions to the accounts. **Keep in mind; you may not transfer money from one account to the other. In addition, you may not change the amount of your annual deduction or cancel the account unless you have a qualifying event that meets IRS guidelines for change.**

**If Money is Left in Your Account at Year End**

It's important to estimate your expenses carefully each year. IRS rules require that you forfeit any unused deposits in your flexible spending accounts at the end of the year. (However, you'll have until March 31 to file claims for expenses incurred through December 31 of the previous year.)

St. Luke's will carry over up to $610 of unused 2024 medical spending account balances. You must be a covered participant through the last day of 2024 to receive these unused funds in a 2025 medical spending account. Amounts in excess of $610 are forfeited. The carryover dollars will be in addition to the annual maximum allowed for 2025. The maximum carryover amount may increase in future years, if it does, St. Luke's will communicate the new maximum carryover amount to you.

If any amount remains unused, St. Luke's may contribute the forfeited funds to the Employee Crisis Fund to support employees in need. (Refer to Appendix Section C for additional information)

## How the Medical Spending Account Works

### Eligible Expenses

You can use a medical spending account to pay for most health care expenses not covered by medical, dental or vision coverage. The following chart provides examples of eligible expenses, as well as expenses not eligible for reimbursement.

| Eligible Expenses | Expenses Not Eligible for Reimbursement |
|---|---|
| ▪ Medical, dental and vision plan deductibles and co-payments<br>▪ Expenses over reasonable and customary limits<br>▪ Medical equipment<br>▪ Hearing Aids<br>▪ Insulin | ▪ Cosmetic Surgery<br>▪ Fitness club dues<br>▪ Premiums for a spouse's health plan<br>▪ Any amounts covered under any other plan provided by a family member |

## Getting Reimbursed

- If your eligible expense may be covered by medical, dental or vision coverage, you must first submit your expenses to that plan first for payment. Provide your Explanation of Benefits (EOB) to support the portion you are responsible for that qualifies for the Medical FSA.
- File claims with Tri-Star through your Tri-Star online account (access information is provided in a welcome letter, sent after the close of open enrollment) or by completing a claim form available through the St. Luke's intranet. Each claim must be accompanied by either the EOB or an itemized statement showing the services provided, date of service and charge for services.
- You have the option of using your FSA debit card to pay your provider for qualified services. You should not file a duplicate claim for the amount paid with your card.
- For medical claims, you may be reimbursed up to the amount you've chosen to contribute for the whole plan year, less any reimbursements already received.

## How the Dependent Care Spending Account Works

### Eligible Expenses

You can use a dependent care account to pay for dependent day care expenses so that you (and your spouse, if you're married) can work.

| Eligible Dependents | Guidelines |
|---|---|
| Your children under age 13 | • Child must be dependent on you for at least 50% of his or her financial support.<br>• Care may be provided inside or outside your home, but not by anyone considered your dependent for income tax purposes, such as one of your older children.<br>• If care is provided by a facility that cares for more than six children, the facility must be licensed. |
| Your spouse or other dependent who is incapable of self-care | • He or she must be dependent upon you, physically or mentally, for at least 50% of his or her financial support.<br>• Care may be provided either inside or outside your home. However, expenses incurred outside your home (such as a nursing home) are eligible only if the dependent regularly spends at least eight (8) hours a day in your household. |

covered by your medical plan, lost wages, childcare, travel, home health care costs or any of your regular household expenses. Compass Critical Illness Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

If you enroll in critical illness insurance coverage, you have access to the Wellness Benefit. The Wellness Benefit provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. This benefit is designed to encourage you to maintain a healthy lifestyle as the tests can help screen for a wide range of potential illnesses and diseases.

To elect or make changes to this coverage you must complete the online benefits enrollment. Changes may only be made during open enrollment. You must elect this coverage for yourself to be able to elect coverage for your dependents. For any enrollment or coverage questions, please contact VOYA at 1-877-236-7564.

**Accident Insurance**

Accident insurance pays you benefits for specific injuries and events resulting from a covered accident. You can use this money however you like, for example: deductibles, childcare, housecleaning, groceries or utilities. Compass Accident Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

If you enroll in accident insurance coverage, you have access to the Wellness Benefit. The Wellness Benefit provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. This benefit is designed to encourage you to maintain a healthy lifestyle as the tests can help screen for a wide range of potential illnesses and diseases.

To elect or make changes to this coverage you must complete the online benefits enrollment. Changes may only be made during open enrollment. You must elect this coverage for yourself to be able to elect coverage for your dependents. For any enrollment or coverage questions, please contact VOYA at 1-877-236-7564.

# Special Services and Discount Programs

## Adoption Assistance

Through adoption assistance, you may be reimbursed up to $3,000 for the adoption of an eligible child – up to three adoptions per calendar year. Reimbursement occurs after the adoption is final and you have submitted a copy of the final adoption paperwork, along with supporting documentation of eligible expenses, to the Human Resources Department. To receive reimbursement, you must make your request within 60 days of the adoption's effective date. Keep in mind, any adoption assistance you receive is subject to taxes. Contact 314-205-6628

## Other Employee Programs:

**Tuition Reimbursement: For more information, please call (314) 205-6628**

**Employee Assistance Program: For more information, please call (314) 729-4650 or call toll free (800) 413-8008, ext. 2.**

**St. Luke's Hospital Fitness Center: To register, contact 205-6849**

**St. Luke's Diabetes Program: Participants who have been diagnosed with diabetes or identified by St. Luke's as eligible for the program may be permitted to participate. For more information, please call (314)-205-6483.**

**For current discounted events and services extended to all St. Luke's Hospital employees, please refer to the list available on the Intranet**. We also have an additional program called **Working Advantage.** This program offers discounts on products, travel, memberships, entertainment and more. You can access this program on the Human Resources Benefits/Saving/Perks list.

To register, click on the link or go to stlukesstl.savings.workingadvantage.com.

# Voluntary Benefits

## ARAG Legal Insurance

ARAG Legal Insurance helps make legal services more affordable and convenient. Legal insurance helps you address everyday situations like dealing with traffic tickets, resolving warranty issues or buying a home. When you need help, don't waste time looking for the right attorney or paying costly attorney fees. Coverage includes Legal Services, Tax Preparation, Identity Theft Protection, Financial Education, Credit Counseling, and Life Event Planning. See the Intranet for detailed coverage options.

St. Luke's offers payroll deductions for your monthly premiums. To elect or make changes to this coverage you must complete the online benefits enrollment. Changes may only be made during open enrollment. If you elect ARAG, you'll receive a packet of information including a membership card.

## Critical Illness Insurance

Critical illness insurance pays a lump-sum benefit if you are diagnosed with a covered disease or condition[1]. You can use this money however you like, for example: to help pay for expenses not

covered by your medical plan, lost wages, childcare, travel, home health care costs or any of your regular household expenses. Compass Critical Illness Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

If you enroll in critical illness insurance coverage, you have access to the Wellness Benefit. The Wellness Benefit provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. This benefit is designed to encourage you to maintain a healthy lifestyle as the tests can help screen for a wide range of potential illnesses and diseases.

To elect or make changes to this coverage you must complete the online benefits enrollment. Changes may only be made during open enrollment. You must elect this coverage for yourself to be able to elect coverage for your dependents. For any enrollment or coverage questions, please contact VOYA at 1-877-236-7564.

**Accident Insurance**

Accident insurance pays you benefits for specific injuries and events resulting from a covered accident. You can use this money however you like, for example: deductibles, childcare, housecleaning, groceries or utilities. Compass Accident Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

If you enroll in accident insurance coverage, you have access to the Wellness Benefit. The Wellness Benefit provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. This benefit is designed to encourage you to maintain a healthy lifestyle as the tests can help screen for a wide range of potential illnesses and diseases.

To elect or make changes to this coverage you must complete the online benefits enrollment. Changes may only be made during open enrollment. You must elect this coverage for yourself to be able to elect coverage for your dependents. For any enrollment or coverage questions, please contact VOYA at 1-877-236-7564.

# St. Luke's Retirement Program

**Retirement Benefits**

Will you have the money you need when you retire? Maybe you want to travel or spend more time with family and friends. No matter how you want to spend your retirement, you'll need the income to do it. St. Luke's offers you two excellent resources to help you build your retirement income:

Your Personal Pension Account Plan and Your Matched Savings Plan

These retirement plans work together to help you build your retirement income.

The Personal Pension Account Plan allows you to watch your pension benefits grow – much like watching a savings account grow! St. Luke's credits the account with a percentage of your pay each year and adds interest credits at a market rate of return.

The second retirement savings opportunity is the Matched Savings Plan. You make pre-tax contributions to your account. As long as you work 1,000 hours in the year, St. Luke's will help you save by matching a portion of the amount you contribute.

These two plans allow you and St. Luke's to work together for your future with long-term retirement and savings plans.

## Personal Pension Account Plan

Your Personal Pension Account Plan offers you these key advantages for building retirement income:

- The Personal Pension Account Plan provides a source of retirement income in addition to any benefits from the Matched Savings Plan and/or Social Security.
- All contributions to the plan are made by St. Luke's.
- St. Luke's credits an amount to your account each year based on your income for that year and your years of benefit service.
- Your account grows at a market rate of interest.
- Each year your account earns interest at the 30 year Treasury Bill rate, or 2.25%, whichever is greater.
- It's easy to understand – you can watch your account grow each year through an annual account statement.
- You can take your account balance with you if you leave and are fully vested in the plan.

**Eligibility**

You're eligible to participate in the plan on the first entry date following one year of eligibility service. A year of eligibility service is a twelve-month period and begins when you are hired and, thereafter, is the calendar year. If you fail to complete 1,000 hours in your first year of employment, the year of eligibility service is then determined based on the calendar year. Once you complete your 1,000-hour year of eligibility service, your participation will begin on the first entry date thereafter (e.g., the first anniversary of your hire date or January 1).

**Vesting**

You are vested in the plan (which means you own your account balance) after five years of vesting service. Once you have met the eligibility requirements, you will receive a year of vesting service for each complete calendar year in which you work at least 1,000 hours. In your final employment year, you will receive a partial year of vesting credit if you are working at a rate of 1,000 hours per year in those years. Please keep in mind you must complete five full years of vesting service to be fully vested.

If you have a period of prior employment with St. Luke's, your employment may count for purposes of vesting service. Contact a representative at St. Luke's Pension Center at 1-866-STLUKE5 (1-866-785-8535) or the Benefits Representative in Human Resources to find out if your prior employment qualifies.

**Contributions to Your Personal Pension Account Plan**

Credits will be made to your account each year of benefit service, determined by the following schedule.

| Your Years of Benefit Service | Amount of St. Luke's Contribution (As a Percent of Your Pay) |
|---|---|
| Less than 3 years | 2% |
| 3 - 4 Years | 2.5 % |
| 5 - 9 years | 3% |
| 10 - 14 years | 4% |
| 15 - 19 years | 5% |
| 20 - 24 years | 6% |
| 25 - 29 years | 8% |
| 30 + years | 10% |

A "year of benefit service" generally means, after you enter the plan, each calendar year in which you work at least 1,000 hours.

"Pay" – up to a maximum of $ $330,000 (legal limit for 2023) – includes salary or wages, overtime, and shift differential, including any pre-tax contributions for flexible benefits or the Matched Savings Plan.

If you have a period of prior or subsequent employment with St. Luke's Hospital, your employment may count for purposes of vesting service. Additionally, your employment may count for purposes of benefit service for the annual pay credit schedule listed above – but not for your opening account balance.

**Interest Credits**
The plan administrator is responsible for investing pension plan assets, calculating the interest your pension account will earn and making annual contributions to the plan to fund your benefit. At the end of the year, your account will be credited with a market rate of interest. The rate is the 30-year U.S. Treasury bill (or "T-bill") rate, but will not be less than 2.25%.

The rate for each year will be set in the prior October. For example, interest for 2024 will be based on the 30-year T-bill rate for October 2023.

**Portability of Your Pension Account**
If you are vested in the St. Luke's Personal Pension Account plan, you will be able to take the pension amount you have earned and roll it into a qualified plan of another employer.

**Account Statements**
Every year you will receive a Total Compensation Statement with an update of your pension account balance. This account statement will allow you to track how your account balance grows through the years and better plan for your retirement.

**How You Receive Benefits**
If your employment ends and you are vested, you have several options for accessing your account. If you leave before retirement:

- You can leave your account in the plan to continue earning interest with your revised date (as long as your balance is over $5,000*); or you can take your account balance with you (if your account balance is less than $1,000, you must take it with you *). If you take your account with you, you will have the option to directly roll over to your matched savings plan account, other qualified IRA, or other qualified employer plans or to receive a lump sum distribution that is taxable to you.
- If you have more than $1,000, but less than $5,000 in your account and you do not make a distribution election, you will receive the distribution via a direct rollover to an IRA as designated by St. Luke's.

**Per Internal Revenue Service guidelines*

When you reach retirement, you can receive your account balance in one of the following ways:

- A monthly annuity for life (if you are single) or a monthly annuity for your life and if your spouse is still living, his or her life;
- A single lump-sum payment; or
- A 10-year certain and life option. This option guarantees a monthly annuity for your life. If you die before receiving benefits for 10 years, your beneficiary will receive payments for the balance of the 10-year period.
- 50% joint survivor annuity option. If you die before receiving your account balance, your beneficiary will receive it. If you are married, your spouse must be your beneficiary, unless your spouse has agreed to your designation of another beneficiary.

**Additional Benefits**
If you are vested in your Personal Pension Account your beneficiary will be entitled to a benefit equal to your Personal Pension Account balance at the time of your death. This provides financial protection for your survivors, whether you're single or married.

If you have 10 or more years of service and you become disabled (under the Social Security Administration criteria), please notify the Benefits Office immediately. Documented notification entitles you to receive contributions and interest on your account until you cease to be disabled, reach age 65, or begin receiving a benefit from the Personal Pension Account Plan. This feature will help you continue to prepare for retirement, even while you are disabled.

**Your Pension Resources (YPR) through AON:**

Your Pension Resources is an interactive website that is available to pension plan participants. You can access the website 24 hours a day, 7 days a week from any computer with internet access. To access the website, go to: https://ypr.aon.com/stlukes (**You must type address into address bar, do not enter via search options.)** YPR allows you to perform an unlimited number of pension estimates based on the dates and assumptions you provide, with a highly customized level of detail. All estimates can be saved on the website for future review and comparison.

Participant data available through the website is encrypted to ensure security. Access is available to plan participants with a correct Social Security Number (SSN) and Password. The first time you access the website you will need a temporary password from AON. You will be prompted to change your password on your first visit to the site. If you cannot locate the password information sent to you from AON, please call the number below. Thereafter, you may change your password at any time. It is a good idea to change it to something that is familiar to you. It should be a combination of 6-20 characters, consisting of letters and numbers and at least one uppercase letter, one lowercase letter and one number. (no symbols) Please keep your password in a safe place. ***No one, including you, can access your pension information on Your Pension Resources without your password.*** If you forget your password, you can have it reset by following the instructions on the website. If you have any questions regarding the Your Pension Resources website, contact St. Luke's Pension Center at 1-866-785-8535. Representatives are available Monday through Friday, 9am – 5pm CST.

# Matched Savings Plan

With the Matched Savings Plan, both you and St. Luke's as your employer work together to build your financial future. The plan offers you unique advantages, including:

**Matching Contributions** St. Luke's makes a matching contribution of 50 cents per dollar on the first 1% of pay that you contribute, plus 25 cents per dollar for the next 3% of pay that you contribute. So if you contribute 4% of pay, you receive another 1.25% of pay from St. Luke's in matching contributions. That's more than a 30% return on your money before any investment earnings or tax savings! You must have at least 1,000 hours of service in a plan year to be eligible for the match. St. Luke's contribution will be made once per year after the close of the year.

**Tax Savings**

- **Tax savings now.** Your pretax contributions are deducted from your pay before income taxes are taken out. This means that you can actually lower the amount of current income taxes you pay each period. It could mean more money in your take-home pay versus saving money in a taxable account.
- **Tax savings later: Roth contributions.** Allows you to make after-tax contributions to your retirement savings plan and take any associated earnings completely tax free at retirement - as long as the distribution is a qualified one.

**What is the Roth contribution option?**

- A Roth contribution to your retirement savings plan allows you to make after-tax contributions and take any associated earnings completely tax free at retirement - as long as the distribution is a qualified one. A qualified distribution, in this case, is one that is taken at least five tax years after your first Roth 401(k) contribution and after you have attained age 59½ or become disabled or die. Through automatic payroll deduction, you can contribute between 1% and 75% of your eligible pay as designated Roth contributions, up to the annual IRS dollar limits.

  For more information, log into your Fidelity NetBenefits account, and search "**Roth**"within the "Library" section of NetBenefits®.

**Investment Choice**
You may invest your entire account (including employer matching contributions) in various investment funds. This gives you the flexibility to choose the investments that are right for your situation.

**Easy Payroll Deductions**
After you make your election, your contributions are automatically deducted from your pay.

**Long-Term Security**
Your account is available when it's needed most…if you leave or retire, if you become disabled, or if you die (in which case it's paid to your beneficiary).

To help you make the most of the Matched Savings Plan, this section also covers tax savings and account growth examples, more investment information, and important plan facts.

**Participation and Vesting**
All employees are eligible to participate in the Matched Savings Plan. To enroll, you can call Fidelity at 800-343-0860 or log on to www.netbenefits.com/stlukeshospital.

You always own your contributions and any earnings on your contributions. You are vested in matching contributions (which means you receive the funds) after three years of service, or permanent disability as defined by Social Security. You will receive a year of vesting service for each complete calendar year in which you work at least 1,000 hours. In your final employment year, you will receive a partial year of vesting credit if you are working at a rate of 1,000 hours per year in those years. Please keep in mind you must complete three full years of service to be fully vested.

For example, if you terminate employment in July 2024, and you worked at the rate of at least 83.3 hours per month in 2023, you will receive 7/12 of a year of vesting credit for 2024. If you are not working at the rate of at least 1,000 hours, you will receive no vesting credit.

You must work 1,000 hours or more in the year to receive matching contributions from St. Luke's.

**Your Contributions**

You choose how much you want to contribute, from 1 % to 75% of your pay. You make this election by phone 1-800-343-0860 or www.netbenefits/stlukeshospital. (Remember, for tax purposes other than FICA, you are reducing your taxable salary.)

The Internal Revenue Service limits the amount you can contribute in pre-tax dollars each calendar year. The Federal general limit is $22,500 for 2023. If you are age 50 or older, your limit is $30,000 for 2023. To stop your contribution so your contribution amount will be less than $22,500 or $30,000 please contact Fidelity at 1-800-343-0860 or log on to NetBenefits at www.netbenefits.com/stlukeshospital. The general and catch-up contribution limits will be indexed for inflation and may be adjusted each year.

You will be notified during the year if federal regulations require your savings to be limited to an amount less than you elect.

To Schedule meeting with a Fidelity Representative:
https://nb.fidelity.com/public/nb/stlukeshospital/contactus/schedule-a-meeting

**Additional Financial Resources:**

Update your Beneficiaries:
https://nb.fidelity.com/public/nb/default/home?option=Beneficiary
Follow the 15% Rule:
https://communications.fidelity.com/wi/2015/savingsandspendingcheckup/
Check out the Latest Financial Webcasts:
https://communications.fidelity.com/tem/WI/webcast/hub/
Learn How we can Help:
https://communications.fidelity.com/tem/ask-us-anything/

**Changing Your Contribution Level**
It's up to you to decide how much you want to save (as long as you stay within the limits listed above). However, if you change your mind and want to increase or decrease your contribution, you can make that change at any time by calling Fidelity at 1-800-343-0860 or going to the website at www.netbenefits.com/stlukeshospital. All changes will take effect within 1 – 2 payroll cycles.

**Employer Matching Contributions**
St. Luke's helps your account grow by matching your contributions, according to the following chart:

| St. Luke's Will Make a Matching Contribution of…. | Based on the … |
|---|---|
| 50 cents per dollar | First 1% of your pay that you contribute |
| 25 cents per dollar | Next 3% of your pay that you contribute |

"Pay" includes salary or wages, overtime, and shift differential, including any pre-tax contributions for flexible benefits – up to a maximum of $330,000 (legal limit for 2023).

Keep in mind that you must work at least 1,000 hours and have an active Fidelity account in the year to receive matching contributions from St. Luke's. As you can see, the match St. Luke's provides on your contributions is significant – no matter what your pay! In addition, your account grows on a tax-deferred basis and receives the benefit of any investment earnings.

**Examples of Employer Matching Contributions**
The match can help increase your savings significantly. But you have to participate to receive the match. You should consider contributing at least 4% of your pay to receive the full match. Otherwise, you're missing out on matching contributions. Here are some examples to show you how much of your contribution your St. Luke's will match:

| Pay | Contribution Rate | Your Contribution | St. Luke's Matching Contribution | Total Contribution to Your Account |
|---|---|---|---|---|
| $30,000 | 4% | $1,200.00 | **$375.00** | $1,575.00 |
| $50,000 | 4% | $2,000.00 | **$625.00** | $2,625.00 |
| $75,000 | 4% | $3,000.00 | **$1,125.00** | $4,125.00 |

**Tax Savings Example**

**Pre-tax Contributions**
Making pre-tax contributions allows you to deduct money from your pay before income taxes are withheld. Eventually, you'll pay taxes on this money but not until you receive money from the plan. To illustrate the value of pre-tax savings, let's look at two employees. Both earn $30,000 in pay per year, are married with two children, and decide to save 5% of pay (or $1,500). Chris opens a savings account at a bank, and Lee joins the Matched Savings Plan. Here's how their savings strategies compare:

| | Chris | Lee |
|---|---|---|
| Annual Pay | $30,000 | $30,000 |
| Pre-Tax Contribution | $ 0 | $ 1,500 |
| Adjusted Gross Income | $ 30,000 | $ 28,500 |
| Federal Income Tax | $ 1,770 | $ 1,545 |
| Social Security Tax | $ 2,295 | $ 2,295 |
| After-Tax Savings | $ 1,500 | $ 0 |
| Take-Home Pay | $ 24,435 | $ 24,660 |
| Annual Tax Savings | $ 0 | $ 225 |
| St. Luke's Matching Contribution | $ 0 | $ 375 |

As you can see, Lee saves $225 on current taxes by saving in the Matched Savings Plan. When you add the $375 employer matching contribution, Lee comes out $600 ahead of Chris. It pays to save in the plan!

Roth Contributions

St. Luke's recently added the Roth option. Unlike a traditional pre-tax contribution, the Roth contribution allows you to contribute after-tax dollars to your account and then withdraw tax-free dollars when you retire.* The following information can help you decide whether the Roth contribution makes sense for you.

**Who might benefit from a Roth 401(k)?**

- Younger employees who have a longer retirement horizon and more time to accumulate tax-free earnings.
- Highly compensated individuals who aren't eligible for Roth IRAs, but who want a pool of tax-free money to draw on in retirement.
- Employees who want to leave tax-free money to their heirs.

*A distribution from a Roth 401(k) is federal tax free and penalty free, provided the five-year aging requirement has been satisfied and one of the following conditions has been met: age 59½, disability, or death.

**Sally's story**
Sally earns $40,000 annually and has elected to put 6% in her Roth 401(k) and 6% in her traditional pretax 401(k) each month.

| | Roth 401(k)† | Traditional Pretax 401(k)† |
|---|---|---|
| Sally's monthly contribution into each account | $200 | $200 |
| Sally's reduction in take home pay is different | $200 | $156 |

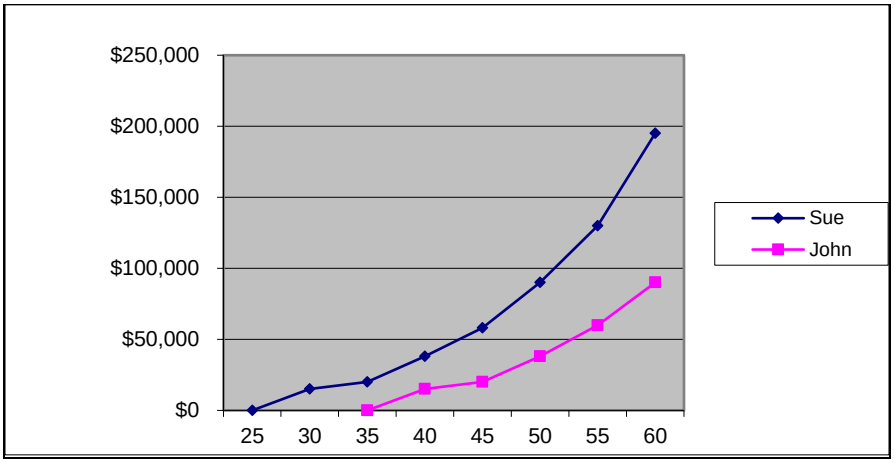
†This hypothetical example is based solely on an assumed federal income tax rate of 22%. No other payroll deductions are taken into account. Your own results will be based on your individual tax situation.

Learn more about the Roth Contribution option by texting ROTH to 343898 to receive a link to a 6-minute video.

Message and data rates may apply. Get details at http://pages.fidelityinvestments.com/smsee.

**Account Growth Examples**
It's not only important to save for retirement, but also to start as early as possible. Here's an example that really makes the point.

John and Sue both save $1,200 each year. While Sue started when she was 25 years old, John waited until he was 35 years old. Let's assume an investment return of 7% per year. As they reach age 60, the value of Sue's account is more than double the value of John's account.




As you can see, Sue will have more than twice as much as John because she started saving 10 years earlier. (John's account has grown significantly, too, but not as much as Sue's.) So start saving early and let the Matched Savings Plan work for you.

**Tools and Resources**

It all starts on NetBenefits at www.netbenefits.com/stlukeshospital

Fidelity's Web site is designed so you can quickly and easily set up, monitor, and manage your retirement savings account.

- If you have a username and password for other accounts at Fidelity, you can use that information to access your retirement account.
- If you do not have a Fidelity username and password, log on to NetBenefits at www.netbenefits.com/stlukeshospital click Register at the top of the screen and follow the step-by-step instructions to set up your account.

**Online Resources to Help you Succeed**

Once your account is set up, it's time to make sure your investment strategy is on track. From practical education to easy-to-use tools and guidance, you now have access to Fidelity's innovative resources and insights to help you make informed decisions.

| **If you want help with:** | **Take These Steps** | **Use this online resource:** |
|---|---|---|
| **Taking Control of Your Financial Future** | Answer just a few questions and you'll be able to:<br>• Estimate how much income you may have---or need---in retirement<br>• Receive guidance to help you get or stay on track<br>• Create a retirement plan in minutes | Planning & Guidance Center |
| **Savings for Retirement** | See how increasing your contributions may help your money grow over time. | Contribution Calculator |
| **Savings for Retirement** | See how your pretax contribution might affect your take-home pay. | Take-Home Pay Calculator |
| **Saving and Spending** | Easily monitor all of your Fidelity and non-Fidelity online financial accounts in one secure place. | Full View |
| | See how your savings and spending compare using a simple rule of thumb. | Savings and Spending Checkup |
| **Investing Strategies** | Determine how to invest your savings among stocks, bonds, and short-term investments | Determine Your Investment Mix Worksheet |
| | Build a portfolio for your retirement income. | Fidelity Income Strategy Evaluator |

**IMPORTANT: The projections or other information generated by Fidelity's Income Strategy Evaluator and Planning & Guidance Center Retirement Analysis tools regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual**

**investment results, and are not guarantees of future results. Results may vary with each use and over time**.

Guidance provided by Fidelity through Fidelity Income Strategy Evaluator and Planning & Guidance Center Retirement Analysis are educational in nature, are not individualized, and are not intended to serve as the primary basis for your investment or tax-planning decisions.

## Investment Options

### Option 1: Target Retirement Date Funds

If you feel more comfortable with an investing approach based on a target retirement date.

The Vanguard Target Retirement Date Funds Investor Shares are designed for investors expecting to retire around the year indicated in each fund's name. Except for the Vanguard Target Retirement Income Fund, the funds' asset allocation strategy becomes increasingly conservative as it approaches the target date and beyond. Ultimately, the funds are expected to merge with the Vanguard Target Retirement Income Fund. The investment risk of each Fund changes over time as the funds' asset allocations change. The funds are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, commodity-linked, and foreign securities. Principal invested is not guaranteed at any time, including at or after the target dates.

If you are looking for a hands-off investment style you may want to consider a Target Date Fund option.

### Option 2: Select from Investment Fund Line up

This option features two types of investment options. Passive Core Investments and Active Core Investments.

**Passive Core Investments**
If I want to pick my own investments, but I want them to be tied to a specific market index.

With this approach you determine and maintain the mix of investments in your Plan account using passive index options. Index options are not actively managed and track the performance of a specific stock or bond index.

**Active Core Investment Options**
If I'm comfortable managing my own investments.

For investors looking for actively managed funds but you are choosing from actively managed investment options representing a variety of investment styles through several investment companies. These options allow you the flexibility to build an investment strategy to meet your needs—both long and short term. The options have different

strategies and goals and invest in specified types of investments including international and domestic stocks, bonds and short-term investments.

**Option 3: Managed Account through Fidelity Personalized Planning & Advice (FPPA)**

If I would like a retirement expert to review and rebalance my account.

St. Luke's Hospital has teamed up with Fidelity to offer a valuable managed account service. It's a new way to help you get, and stay, on course toward your retirement goals. With Fidelity Portfolio Advisory Service at Work, you get active retirement account management. This means that Fidelity's team of investment professionals invest, monitor, and rebalance your account as needed to adjust to changes in the market, or changes to your situation.

Fidelity Guidance Professionals are available to answer any questions you may have about this managed account service. Call 1-800-343-0860 for more information.

Fidelity Portfolio Advisory Service at Work is a service of Strategic Advisers, Inc., a registered investment adviser and a Fidelity Investments company. **This service provides discretionary money management for a fee, which will be paid from your account.**

**Additional Plan Option - 457b Plan**

In addition to St. Luke's matched savings plans, participants who are determined to be eligible may participate in St. Luke's Hospital Section 457(b) Plan. This plan is not a qualified plan, but it does offer additional tax deferral of income for those employees who want to exceed the contributions outlined in the matched savings program. While the plan offers additional savings opportunities, it is important to note there are certain guidelines in place for distribution of any income deferred under the 457b plan when leaving St. Luke's employment.

Under this plan, a participant's benefit is to be distributed in a single lump sum within 6 months following termination of employment with St. Luke's Hospital, unless the participant has timely elected a later date for distribution of his or her benefit to commence. In addition to electing a later commencement date, the participant may also elect to have the benefit paid in a lump-sum cash payment or in substantially equal semiannual, annual or monthly installment payments over a period of years not longer than five years. The distribution of the participant's benefit under the plan must satisfy the requirements of Code Section 401(a) (9), and must commence no later than the first day of April of the calendar year following the later of (i) the calendar year in which the participant attains age 70 ½, or (ii) the calendar year in which the participant's employment with St. Luke's Hospital terminates.

**Loans**

You may also take a loan from your Matched Savings Plan account for up to the lesser of $50,000 or 50% of your contributions, and vested earnings (minimum loan is $1,000). Some key features of the loan program are;

- Eligibility for loans would be for full time or part time employees only.
- Loan repayments are made monthly through ACH deductions from your personal checking or savings account.
- You have up to five years for repayment of personal loans and up to 15 years for repayment of residential loans.
- Interest rate is 1% over prime.
- You may continue to contribute to the Matched Savings Plan during the repayment process.
- A modest loan application fee and annual loan amortization fee will be charged to your account.

**Hardship Withdrawals**

You may be able to take a partial withdrawal from your elective contributions account balance while you're working. Documentation to support the request must be submitted to Fidelity prior to hardship approval. All withdrawals are subject to taxes. You may withdraw your contributions, but not earnings on those contributions, to meet an immediate and substantial financial hardship. According to government rules, here are some examples of financial hardship:

- Payment of college tuition expenses;
- Significant medical expenses not covered by a medical plan;
- Purchase of your primary residence;
- Prevention of foreclosure on your primary residence; or
- Payments for burial or funeral expenses for the participant's parents, spouse, child, or dependents.

The minimum withdrawal amount is $500. Your withdrawal will be paid in a lump sum and is subject to ordinarily income tax plus 10% penalty tax if you have not reached age 59 ½ or met other exceptions.

**Rollovers**

You may elect to directly roll over on eligible distribution to another employer's qualified plan or to an Individual Retirement Account (IRA). The rollover request should indicate the receiving financial institutions information.

**Distributions**

When you leave or retire, you may receive the value of your vested account. If your account balance is $1,000 or less, you will automatically receive a lump-sum payment of your account balance. If you have more than $1,000 and less than $5,000 in your account and you do not make a distribution election, you will receive the distribution via a direct rollover to an IRA as designated by St. Luke's. If your account balance is more than $5,000, you can request:

- A lump-sum payment* of your entire account balance;
- To leave your account balance in the plan and take it as a lump sum at a later date, but no later than April 1 after the year in which you turn 70 ½; or

- Periodic partial payments.
- Adjusted payments are made on a monthly basis to you and a continued monthly payment, after your death, equal to 50% to your surviving spouse.

At the time of your distribution, please seek financial advice to determine your tax impact.

*Lump-sum distributions can be rolled over tax free to a qualified IRA. Most financial institutions may be able to provide you with information on an IRA that has an annuity purchase option.

**In-Service Distribution**

If you are 59 1/2 or older and vested in the Matched Savings Plan you are eligible to take one lump sum distribution per calendar year. This distribution would be treated as income for tax purpose, and you would receive a 1099 form from Fidelity.

**Administrative Expenses**

A quarterly administrative fee for providing plan record keeping and investment services will be charged to your Matched Saving Plan investment account.

**Creating Your Own Investment Plan**

One of the advantages of the Matched Savings Plan is that it is flexible, so you can choose investments that are appropriate for your situation. How do you do that? Well, each person may have a different approach, but here is some information on the key steps you may take to create your own investment plan.

**Set Your Goals**

Before investing, you need to think about your savings goals. To develop an effective financial strategy, consider how much time you have until you will need the money, as well as:

- **Your age and time horizon.** Your needs and goals change during your life. For example, if you are younger and have a long career ahead of you, you may consider more aggressive investments and focus on long-term growth. As you near retirement, you may become interested in more traditionally stable investments to protect your retirement savings.
- **Your other sources of retirement income.** How your other retirement assets are invested may influence how you invest in the plan. Remember, you will also have the Personal Pension Account Plan, which earns a fixed rate of interest at the 30-year T-bill rate, as another source of retirement income.

**Diversify Your Investments**

Most experts agree that you should diversify – or spend your money among different types of investments in order to reduce your risk. The theory is that if some investments drop in value, others may gain or hold their value and offset the drop. You can diversify by buying several varieties of one type of investment (like mutual funds that invest in stocks) and by choosing different investment categories that may not be tied to the same economic, currency fluctuations, and political developments. Of course; you can experience gain or loss with any investment.

**Balance your Investment Risk**
No investment is without risk. Your attitude about risk can help determine the best investment strategy for you. To make sound investment decisions, you need to know what kind of risk you're facing and then pick investments you can live with. If you are uncomfortable investing in the stock market, then perhaps you should limit the amount you invest in stocks.

Two types of risk you need to understand are market risk and inflation risk.

- **Market risk.** This is the likelihood that the value of your investments will go up—or down—at any time.
- **Inflation risk.** This is the likelihood that the value of your investments won't keep up with inflation over the long haul. Inflation risk is low in the short term, but it has a greater impact over time.

Most investments involve a trade-off between market risk and inflation risk. Conservation investments (like money market funds) may provide more protection against market risk, but less protection against inflation risk. More aggressive investments (like funds invested primarily in stock) provide greater inflation protection over time, but have higher market risk.

**PUTTING YOUR PLANS TOGETHER**
The Personal Pension Account and the Matched Savings Plan provide a way to build retirement income. However, there are differences between the plans. Let's look at how they compare:

| | **Personal Pension Account Plan** | **Matched Savings Plan** |
|---|---|---|
| Eligibility | One Year of Eligibility Service | Immediate |
| Enrollment | Automatic | You |
| Vesting | 5 Years of Service | Immediate for your contributions & earnings; three years of service for matching contributions and earnings |
| Contributions | St. Luke's | You & St. Luke's |
| Investment Decisions | St. Luke's | You |
| Who Assumes Investment Risk? | St. Luke's | You |
| Guaranteed Return | Yes | No |
| Investment Options | None | Various funds |
| Loans | No | Yes |
| In-Service Withdrawals | No | Yes, if age 59 1/2 or older |
| Choice of Payment Options | Yes | Yes |

As you see, the Personal Pension Account Plan places investment responsibility on St. Luke's. In the Matched Savings Plan, you have the primary responsibility.

**Increasing Your Retirement Income**
Your future financial security is a shared responsibility between you and your employer. The organization provides the Matched Savings Plan and the Personal Pension Account Plan, and makes valuable contributions to both as well as to Social Security. But you also have responsibilities:

- To review your financial goals periodically;
- To contribute to the Matched Savings Plan;
- To invest your Matched Savings Plan contributions appropriately, based on how long before you retire or have other needs for your funds, your tolerance for risk, and goals for the future; and
- To monitor your progress by reviewing your plan statements.

## Planning for Retirement

If you are planning on retiring in the near future here are a few things to consider:

**What is the process to apply for Medicare or receive Social Security payments?**

- Visit your local Social Security Office to learn about the benefits available to you.
- The National Toll Free number is 1-800-772-1213.
- To find a location near you go to http://ssaofficelocator.com.
- Some offices close to St. Luke's are 1215 Fern Ridge Parkway, STE 100, Creve Coeur, MO 63141 or 650 Gravois Bluffs, Fenton, MO 63026

**Helpful information about Medicare**:

- What is Medicare Part A: Medicare Part A covers Medicare inpatient care, including care received while in a hospital, a skilled nursing facility, and home health care.

- What is Medicare Part B: **Medicare Part B** (medical insurance) is **part** of Original **Medicare** and covers services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment.

- What is Medicare Part C: **Medicare Part C** is not a separate benefit. **Part C** is the **part** of **Medicare** policy that allows private health insurance companies to provide **Medicare** benefits. These **Medicare** private health plans, such as HMOs and PPOs, are known as **Medicare** Advantage plans.

- What is Medicare Part D: **Medicare Part D**, also called the **Medicare** prescription drug benefit, is a United States federal-government program to subsidize the costs of prescription drugs and prescription drug insurance premiums for **Medicare** beneficiaries.

**What about St. Luke's health insurance coverage?**

- To continue with your St. Luke's insurance, see the Continuation of Coverage section of the Benefit Summary Book.
- To learn about Market Place Insurance, see the Continuation of Coverage section of the Benefit Summary Book.

**What about extending St Luke's life insurance coverage?**

- Life insurance coverage ends with your last day of employment. If you want to convert your supplemental life insurance to an individual plan please contact the carrier within 30 days of your retirement at 1-800-421-0344. Rates will be different for an individual plan and all coverage options may not be available. Please provide this number **423744** when you call along with the number of increments you currently have and the dollar amount of the coverage you are wanting to convert.

**Process for Employees eligible for a Pension Distribution:**

- The pension process begins when you move to a terminated status
- Please update Lawson Employee Self-Service before you leave to make sure address and marital status information is current so you will receive your packet promptly.
- The pension packet will contain all the paperwork you will need to complete to receive your pension funds. Your pension packet will include a commencement date determined by Aon. This is the date that your payments will be effective. For example, if your commencement date is August 1st but your paperwork is received after this date you may be eligible for a retro-payment back to August 1st depending on which pension option you pick.
- To receive a pension distribution, you must be separated from employment. An active employee in a PRN status will not qualify for a pension benefit distribution.
- The first step is for payroll to complete distribution of any final paychecks. This may take 30 to 45 days.
- Aon will then create your pension packet and it will be mailed to your home. This can take 2 – 3 weeks.
- You will need to complete the appropriate paperwork from your packet and return it to Aon for processing. Once received Aon will send it to St. Luke's for administrative approval and then it is sent to the bank for disbursement.

- The pension payment process may take up to 4 months before you see your first payment. For example: If you retire on December 31st, you can anticipate your first payment will be received in April.
- If you select annuity payments, the timeline will extend by approximately one month to allow time to get the payments set up for ongoing distribution.

**Process for employees eligible for a Matched Savings Distribution**

- Contributions you have made to your matched savings account become available for distribution as soon as your employment with St. Luke's ends.
- Distribution, partial distribution, or rollover paperwork must be completed with Fidelity directly. The Service Center number is 1-800-343-0860.
- To receive St. Luke's matching contributions; you must be vested with a minimum of three years of service with 1,000 hours or more per year.
- The processing time for a distribution from Fidelity is generally 7 – 10 business days.

**Additional Resources**

- Fidelity Representative (Matched Savings) 800-343-0860
- Aon Representative (Pension) 1-866-785-8535
- Benefit Representatives 314-205-6016

# APPENDIX

# SECTION A

# SPOUSAL COVERAGE

Spousal Affidavit/Certification Form

# ANNUAL SPOUSAL AFFIDAVIT/CERTIFICATION FORM FOR 2024 BENEFITS

Team Member Name _____ Employee ID#_____

Spouse's Name _____

Spouse's Employer _____

## Fax completed form to 314-336-5229 or email to St. Luke's Benefits

St. Luke's offers medical coverage to team members, spouses, and family members. St. Luke's preference is that spouses be covered by the spouse's employer as their primary coverage. Therefore**,** St. Luke's has a spousal surcharge when a spouse has other employer-provided coverage available. To determine your appropriate medical premium, please complete the following if a spouse is being added to the St. Luke's health plan for 2024. **Update required yearly.**

**Section 1**

Is your spouse currently employed? Yes _____ No _____
If YES, complete the next question.
If NO, sign and date below and return the form.

Is your spouse self-employed and does **not** have group medical coverage available? Yes _____ No _____
If YES, please sign, date below and return the form.
If NO, your spouse is not self-employed, complete the next question.

Is your spouse currently ***eligible for coverage*** through an employer's group health plan? Yes _____ No _____
If YES, please sign and date below and return the form.
If NO, please have your spouse's employer complete Section 2 to verify.

I certify that the above information is correct. I acknowledge that if it is discovered that my spouse has been offered other medical insurance through their employer, all monies will be recouped for claims paid through the medical insurance plan. I also understand that this form must be completed and sent to the **Benefits Office at** slhstlukesemployeebenefits@stlukes-stl.com to complete enrollment. If the form is not returned, the spousal surcharge will apply. There is no refund for late forms.

Signature _____ Date _____

---

**Section 2**

**Verification of Benefits (To be completed by spouse's employer)**
Please provide the following information for your employee who is listed at the top of this page.

Do you maintain a group healthcare plan for your employees? Yes _____ No _____

If yes, is this employee eligible for medical coverage? Yes _____ No _____

_____ _____
Name of Employer Representative Title

_____ _____
Signature of Employer Representative Date

Contact Phone Number _____

# SECTION B

## EXPLANATION OF BENEFITS/ID CARDS

UMR Explanation of Benefits
Medical and Dental

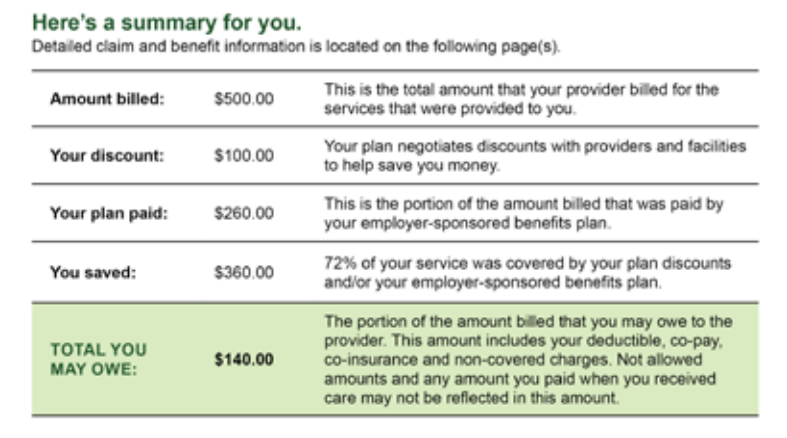
UMR – Understanding your ID Card
Medical and Dental

# Understanding your EOB, as easy as 1-2-3

**An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about how your recent medical service was covered by your benefits plan. You'll receive a bill from your provider for any amount you may owe.**

## 1 Cost summary

The first page of your EOB is a summary of how much your provider billed, how much was covered by your plan and the total you may owe to your provider.



**Here's a summary for you.**
Detailed claim and benefit information is located on the following page(s).

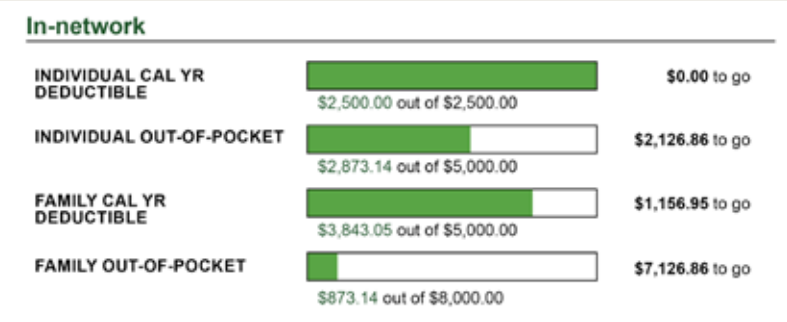
| | | |
|---|---|---|
| **Amount billed:** | $500.00 | This is the total amount that your provider billed for the services that were provided to you. |
| **Your discount:** | $100.00 | Your plan negotiates discounts with providers and facilities to help save you money. |
| **Your plan paid:** | $260.00 | This is the portion of the amount billed that was paid by your employer-sponsored benefits plan. |
| **You saved:** | $360.00 | 72% of your service was covered by your plan discounts and/or your employer-sponsored benefits plan. |
| **TOTAL YOU MAY OWE:** | **$140.00** | The portion of the amount billed that you may owe to the provider. This amount includes your deductible, co-pay, co-insurance and non-covered charges. Not allowed amounts and any amount you paid when you received care may not be reflected in this amount. |

## 2 Benefits update

On the next page, you'll find a breakdown of how much you and/or your family have applied toward your annual deductibles and out-of-pocket amounts.

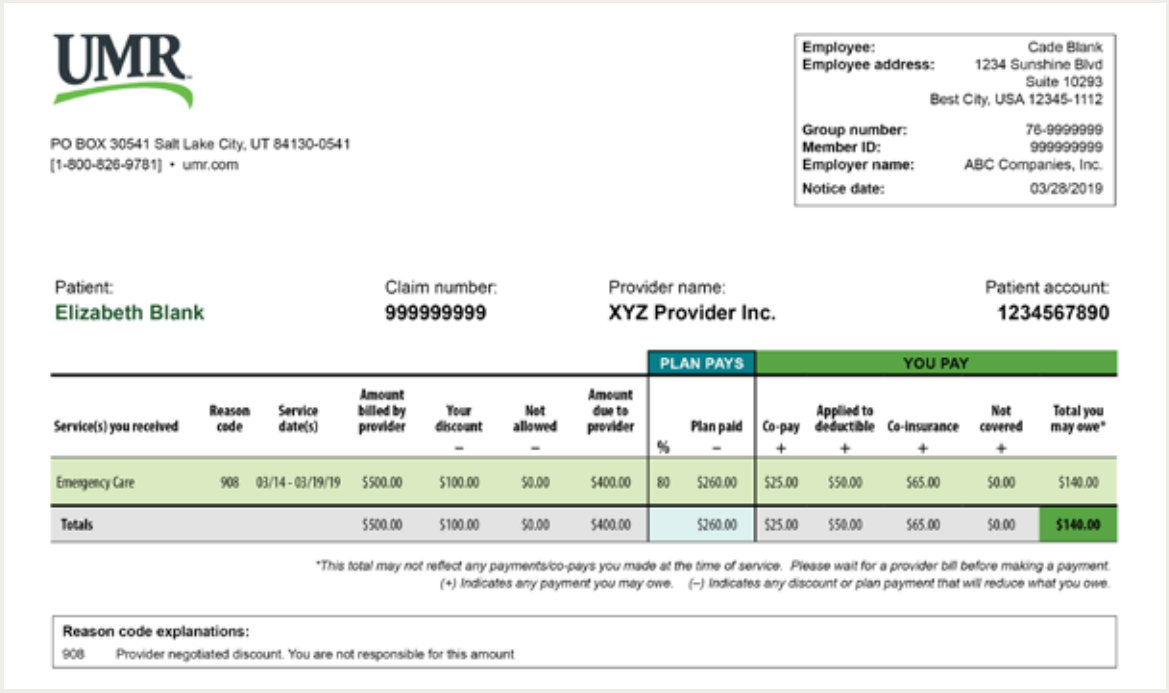
***Deductible:*** *The amount you have to pay before your plan pays for specified services. Deductibles are usually an annual set amount.*

***Out-of-pocket:*** *The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you reach your "to go" amount, the plan will usually pay 100% of the allowed amount.*



**In-network**

| | | |
|---|---|---|
| **INDIVIDUAL CAL YR DEDUCTIBLE** | $2,500.00 out of $2,500.00 | **$0.00** to go |
| **INDIVIDUAL OUT-OF-POCKET** | $2,873.14 out of $5,000.00 | **$2,126.86** to go |
| **FAMILY CAL YR DEDUCTIBLE** | $3,843.05 out of $5,000.00 | **$1,156.95** to go |
| **FAMILY OUT-OF-POCKET** | $873.14 out of $8,000.00 | **$7,126.86** to go |



UMR

PO BOX 30541 Salt Lake City, UT 84130-0541
[1-800-826-9781] • umr.com

| | |
|---|---|
| Employee: | Cade Blank |
| Employee address: | 1234 Sunshine Blvd<br>Suite 10293<br>Best City, USA 12345-1112 |
| Group number: | 76-9999999 |
| Member ID: | 999999999 |
| Employer name: | ABC Companies, Inc. |
| Notice date: | 03/28/2019 |

Patient: **Elizabeth Blank**
Claim number: **999999999**
Provider name: **XYZ Provider Inc.**
Patient account: **1234567890**

| | | | | | | | PLAN PAYS | | YOU PAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount − | Not allowed − | Amount due to provider | % | Plan paid − | Co-pay + | Applied to deductible + | Co-insurance + | Not covered + | Total you may owe* |
| Emergency Care | 908 | 03/14 - 03/19/19 | $500.00 | $100.00 | $0.00 | $400.00 | 80 | $260.00 | $25.00 | $50.00 | $65.00 | $0.00 | $140.00 |
| Totals | | | $500.00 | $100.00 | $0.00 | $400.00 | | $260.00 | $25.00 | $50.00 | $65.00 | $0.00 | $140.00 |

*This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**
908 Provider negotiated discount. You are not responsible for this amount

## 3 Service and payment details

This section includes information about who received the medical service, the name of the provider and what types of care they received. It gives you a breakdown of how the claim was processed, including:

- How much your provider billed
- Your network discount
- The amount paid by your employer-sponsored plan
- The amount you may owe, including co-pays, deductibles and out-of-pocket amounts

**Go paperless on umr.com**

**Sign up for digital EOBs** and you'll receive email reminders every time you have a new EOB. PLUS, we'll let you know if you need to take action on the EOB and give you more details about your claim.

UMR
A UnitedHealthcare Company

# Understanding your new ID card

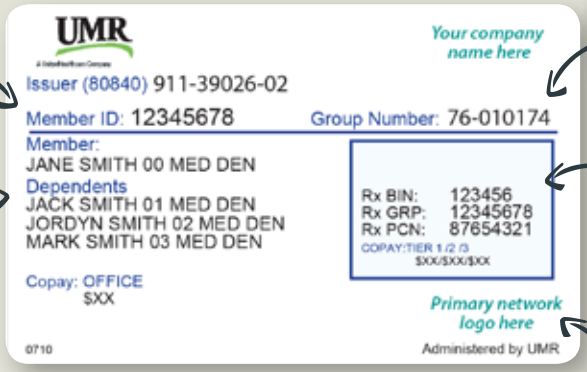

## Have you ever wondered what all that stuff on your ID card really means? Here's a sample of what you might see. Each plan is different.

The number assigned specifically to you to track all of your benefits and claims information.

The number assigned to identify your group health plan.

A list of the family members who are covered under your plan.

Information about your prescription drug plan. Pharmacists use this to process your claims.



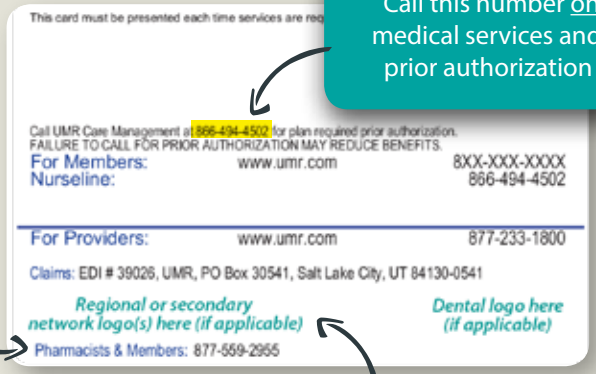

Your medical provider network, also referred to as your preferred provider organization (PPO). Going to doctors, clinics and hospitals in your network will save you money.

## More on the back

Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to **umr.com** to check your benefits, claims status, accumulators and eligibility.

Call this number only when you need medical services and your plan requires prior authorization for those services.

Call this number when you have questions about pharmacy benefits.




If you're traveling outside your in-network coverage area, look to see if you have access to a regional or secondary network.

UMR
A UnitedHealthcare Company

# **Pay less for dental care** with UnitedHealthcare Dental PPO

## Welcome to the club!

Your employer allows you and your family members to see any dentist you want. As an added bonus, you now have access to the UnitedHealthcare Dental PPO network that could save you money.

The UnitedHealthcare Dental PPO network is simply a very large group of dentists who have agreed to provide their services at a discounted rate. There's a good chance your current dentist already is a member of the network.

## No plan changes, just a new ID card

There are no changes to your dental plan benefits. The dental logo on your UMR ID card automatically makes you eligible for discounts. So there is no extra work on your part.

## How it works

If your dentist is in the UnitedHealthcare Dental PPO network all you need to do is show your UMR ID card at your next appointment. A discount will then be applied to your bill, saving you money!

If your dentist is not currently a part of the UnitedHealthcare Dental PPO network, you have three choices:

1. Continue to see your current dentist as you have in the past*
2. Choose a different dentist who is part of the UnitedHealthcare Dental PPO network
3. Ask your dentist to apply to join the network

* **Please note:** You will not receive network savings if you choose option 1.

## Finding an in-network dentist

- Call the toll-free number listed on the back of your UMR ID card – **1-800-826-9781**
- Or visit **umr.com** on your computer or mobile device:

  Select **Find a provider** from the home page

  Choose **Dental**

  Type **UnitedHealthcare Dental PPO** in the search box or use the alphabetical listing

If you have any questions about the UnitedHealthcare Dental PPO network, please call the UMR Customer Service number on the back of your ID card.

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A UnitedHealthcare Company

## SECTION C

## FLEXIBLE SPENDING/HEALTH SAVINGS INFORMATION

Health Savings Account Frequently Asked Questions

Tri-Star – Health Reimbursement Account – HCRA

Tri-Star – Know Your Health Care FSA
Eligible and Ineligible Expenses

Tri-Star – Dependent Care Reimbursement Account – DCRA

Tri-Star – Using My Flexible Spending Account (FSA)
Debit Card

Tri-Star Online Account Management

## Health Savings Account Frequently Asked Questions

**St. Luke's offers a high deductible health plan (HDHP). This HDHP also includes a Health Savings Account that can be used to pay for qualified medical expenses or to save for future medical expenses.**

**What is A Health Savings Account?**
A Health Savings Accounts (HSA) is a tax-advantaged savings account under Code Section 223 that an individual or an employee may establish and put money into on a tax-advantaged basis to save for current and future qualifying medical expenses. It also allows individuals to take charge of how their health care dollars are spent. Designed to work together with an HSA-eligible health plan, an HSA can be used to pay for qualified medical expenses such as doctor visits, prescriptions and even some over-the-counter medications. The HSA is often referred to as a "medical 401(k)", because the account is owned by the individual or employee (it is not a group plan), earns tax free interest, rolls over from year to year, and moves with the employees wherever they go: to a new job, a change in health plans or even in retirement.

- Anyone who buys a qualified high deductible health plan (one that meets the requirements the government has determined), with at least a $1,600 single or $3,200 family deductible, qualifies for an HSA.
- The money you deposit into your Health Savings Account, as well as earnings are tax deferred. You can withdraw money at any time to pay for qualified medical expenses, without being penalized.
- You can even roll over unused balances from year to year.

**How can I save with an HSA?**

- Contributions can be made through payroll deduction into an HSA on a pre-tax basis.
- You can earn tax-free interest on HSA contributions and use that money to pay for qualified medical expenses.
- Withdrawals from the HSA are tax free if used for qualified medical expenses
- Unlike Flexible Spending Accounts, HSAs have **no "use it or lose it"** requirement and can also stay with employees when they change jobs or retire.

**Does St. Luke's contribute to my account?**

- Yes. St. Luke's will contribute $500 for individual coverage accounts and $1000 for employee plus children, spouse or a family. This amount will be prorated for new employees starting after January.

**What is the maximum amount I can contribute pre-tax in 2024?**

- The maximum an individual can contribute to an HSA in 2024 is $4,150 and the most a family can contribute is $8,300. This amount does have to include any employer contribution. Since St. Luke's is contributing $500 for individuals and $1000 for other accounts, the maximum an employee can contribute in 2024 is $ 3,650 and the maximum employee plus family can contribute is $7,300. Employees 55+ years of age can contribute an additional $1,000 totaling $4,650 for individuals and $8,300 for family.

**How do I access my HSA funds?**

- When you open an account, you are issued a Bank of America **HSA Visa® debit card** that makes it easy to pay for qualified medical expenses.
- You also have **online access to account transactions**, so keeping tabs on medical spending is easy. Once you enroll, you will receive a welcome packet with information on how to access your account.

**How can I use my account savings?**

- Standard medical services such as office visits and annual medical physicals.
- Prescriptions, some over-the-counter medicines, and health care products.
- Preventive and restorative dental care, as well as orthodontia for children and adults.
- Eyeglasses, contact lenses, and laser eye surgery.

**What happens to my HSA if I am no longer enrolled in an HSA-compatible health plan?**

- You will no longer be eligible to contribute to the HSA. However, you will still have access to the HSA, and can use the funds as you choose. Withdrawals for qualified medical expenses will still be tax-free.

**Can I contribute to my Flexible Spending Account if I have an HSA?**

- You are not eligible to contribute to a Medical Spending Account if you are in the HDHP and have an HSA. You can still contribute to the Dependent Care Spending Account.

**Can my HSA earn interest?**

Yes, funds in your HSA earn interest, and interest earnings are tax-free.

| Balance | Annual percentage Yield |
|---|---|
| $0.00 to $2,500.00 | 0.10% |
| $2,500.01 to $7,500.00 | 0.20% |
| $7,500.01 to $10,000.00 | 0.25% |
| $10,000.01 to $25,000.00 | 0.35% |
| $25,000.01 and over | 0.45% |

**If I make payroll deduction contributions to my HSA, when will the money be available?**

- Initial funding may take 2 – 3 weeks for deposit of St. Luke's seed money. You can pay out of pocket for eligible expenses and then reimburse yourself once the seed money has been posted to your account.
- If you already have a personal account with Bank of America, your contributions will be available in your account after 2 business days. If you do not have a Bank of America account, it will be available after 4 days.

**Do I earn interest on my Health Savings Account?**

- You do not earn interest on the account, however if you exceed a threshold, you can elect to direct your contributions to mutual fund investment options. You would then be entitled to any earnings (or losses) based on the performance of the funds. You would need an account balance of $1000 or greater to take advantage of the investment options.

**What happens to my account if I leave St. Luke's or retire?**

- Your account will remain yours; however, you would be responsible for the monthly account fees.

**Who do I contact for more information?**

- Bank of America Customer Care Center at 800-718-6710. Customer Service representatives are available 24/7/365.
- **HSA Resource Center** at: **http://healthaccounts.bankofamerica.com**

**Additional Websites:**

https://healthaccounts.bankofamerica.com/hsaguide/

https://healthaccounts.bankofamerica.com/assets/pdf/investment_menu_core_consumer.pdf

IRS Publication 969 https://www.irs.gov/pub/irs-pdf/p969.pdf

https://www.irs.gov/pub/irs-pdf/p502.pdf

https://healthaccounts.bankofamerica.com/index.shtml

**Click this Enrollment Link to begin the enrollment: https://myhealth.bankofamerica.com/Login.aspx?sec=BRL-RTLBOA**

**What to expect after completing your online enrollment:**

- You will not receive an email confirmation.
- It will take approximately 1-2 business days to process your HSA application.
- Once the account is set up, a Welcome Kit will be delivered to your email address. You will receive a Bank of America Health Savings Account Visa® debit card in the mail within 7 business days.
- You can access your HSA account at: **https://myhealth.bankofamerica.com**
- Once your new HSA account is active, and you complete a Transfer Request Form and submit it to your existing HSA provider. The HSA provider will generate a check for your HSA funds and mail it directly to Bank of America. Once the check is received, it will go through the deposit process and funds will be posted to your new Bank of America HSA account.

Employee Benefit Plan Information

# Health Care Reimbursement Account - HCRA

## Why Participate?

You can save taxes! Employees have the opportunity to participate in comprehensive medical and dental plans but may still be responsible for copays, deductibles, coinsurance, prescription costs, vision care and orthodontia.

The ***Health Care Reimbursement Account*** (HCRA) allows you to take advantage of current tax laws (IRC Section 125) to pay for these expenses with **pre-tax dollars**. Your tax savings can be significant, but maximizing your benefits requires understanding the plan and some planning.

## *How Does This Work?*

- Elect to make pre-tax payroll contributions into an account, during open enrollment or as a new hire.
- After the plan year begins (or coverage as a new hire), you, your spouse or your dependent incur qualifying medical expenses.
- Access funds in your account:
  - File a claim and provide the appropriate supporting documentation as indicated.

**Note: The full amount you elect to deposit in your HCRA for the year is available to you at any time after January 1st (or coverage effective date for new hires).**

## *Managing Your Account*

You will have a unique secure account with Tri-Star, available on Tri-Star's website **FSA.help/login** where you can:

- File claims & upload documentation,
- Sign up for Direct Deposit for claims payments (***Once established, direct deposit information is retained from year to year.),***
- Update your email address to receive all communications from Tri-Star,
- View previous claims & payments,
- View your available balance,

## *Account Access - Mobile*

You can manage your account from any smart phone or device.

Go to **FSA.help/login** and save the website URL for quick access any time. After you Login:

- Click on the account name/balance,
- File claims,
- Upload Documentation to share your supporting documentation (upload a picture with your phone),
- You'll receive a payment notice via email when your reimbursement is on it's way to you!
- View all claims you have filed against your account,
- See payment details,
- Review your account summary.

Use your profile in the top right corner for more options!

### *Internal Revenue Code Regulations*

- You must enroll each Plan Year to participate (electing between $130 & $3,050).
- Expenses claimed from your account must be incurred during the Plan Year (January 1—December 31).
  - Funds must be claimed by March 31 following the end of each Plan Year.
    - Up to $610 of funds remaining on March 31 roll to the next plan year. Remaining funds in excess of $610 are forfeited.
    - Funds remaining less than $5 will not roll over if you do not enroll and contribute to the account for the new plan year.
    - Rollover funds only roll to the immediately following plan year unless you continue to enroll and contribute to the account in succeeding plan year.
- Your contributions each pay period must remain the same all year unless you experience a "qualifying change in status event" and change your election, as allowed by the Plan Document.
- You may not claim any expense reimbursed from this account as an itemized deduction on your tax return.

TRI-STAR SYSTEMS

**CLAIMS ADMINISTRATOR**

16401 Swingley Ridge Road
Suite 250
Chesterfield, MO 63017

Phone: 800-727-0182, Option 1
www.tri-starsystems.com

### *Estimating Your Expenses*

We recommend you review the deductible and coinsurance provisions of your medical and dental plans, and look at your out-of-pocket medical expenses over the past year or two to plan your annual election. Expenses incurred by you or your dependents qualify regardless of whether you participate in any of your employer's medical or dental plans.

Many expenses like orthodontia payments, drug copayments and physicals are easily predictable. Others, like eyeglasses and hearing aids may be deferred or accelerated from one plan year to another depending upon the balance of your account.

### *Health Care FSA Debit Card*

Using the FSA debit card pays your medical provider with funds available in your account. Your provider is paid when the transaction is approved. However, you may be required (under IRS regulations) to support this transaction with a statement showing the services provided.

**Use of the card is optional and may eliminate some substantiation requirements. *Please read about how and where the card works by reviewing the flyer "Using My FSA Debit Card."***

**Participants should retain cards they already have from Tri-Star since these are good for 5 years, until the card expiration date. New participants will receive cards after they enroll and must activate it prior to using it for the first time. Always keep your service statements in case they are required by Tri-Star or by the IRS.**

### *More Information*

**Refer to IRS Publication 502, Medical and Dental Expenses at www.irs.gov for more details on potential eligible health care expenses.**

**Obtain the Summary Plan Description from your employer for plan specifics on eligibility, termination, changes in status, etc.**

**Watch the 2 minute video using your smart phone or device (using the QR code).**

# Know Your Health Care FSA Eligible and Ineligible Expenses

*Maximize the Value of Your Reimbursement Account* - Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses that qualify as federal income tax deductions under Section 213(d) of the Internal Revenue Code ("IRC"). More info.

- Health Care FSA dollars can be used to reimburse you for medical and dental expenses incurred by you, your spouse or eligible dependents (children, siblings, parents and other dependents which are defined in your Plan Documents).

*IMPORTANT:* The IRS defines which medical expenses are eligible under a tax-deferred account. Not all expenses are eligible under all plans. If you are unsure of what your Health Care FSA dollars may be used for, please contact your Plan Administrator.

Here is a sample list of expenses currently eligible and not eligible by the Internal Revenue Service ("IRS") as deductible medical expenses. This list is not necessarily inclusive or exclusive, and may be subject to change based on regulations, IRS revenue rulings and case law. It is solely based on our current interpretation of IRC Section 213(d) and is not intended to be legal advice.

For a complete up-to-date list of FSA Eligible Products & Services please reference IRS site.

## Sample List of Eligible Expenses

### BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

### DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

### EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

### MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Personal Protective Equip. (masks, etc.)
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

### MEDICATIONS
- Insulin
- Prescription Drugs

### OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

### PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

## Sample List of Eligible Expenses

### HEARING
- Hearing Aids and Batteries
- Hearing Exams

### LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

### MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

### THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, **expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement.** For additional information, check your Summary Plan Document or contact your Plan Administrator.

## Sample List of Eligible Over-the-Counter Medicines and Drugs

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiphrastic treatments
- Antiseptics & wound cleansers
- Anti-diarrhea's
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Contraceptives
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care
- Eye care
- Feminine antifungal & anti-itch
- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment
- Hemorrhoidal preps
- Homeopathic remedies
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers
- Medicated respiratory treatments & vapor products
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated vapor products

OTC items that are not medicines or drugs remain eligible for purchase with FSAs. You can use your FSA for these items.

## Sample List of Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- **Baby Electrolytes and Dehydration**
  Pedialyte, Enfalyte
- **Contraceptives**
  Unmedicated condoms
- **Denture Adhesives, Repair, and Cleansers**
  PoliGrip, Benzodent, Plate Weld, Efferdent
- **Diabetes Testing and Aids**
  Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
  Thermometers, blood pressure monitors, cholesterol testing, COVID test kits
- **Ear Care**
  Unmedicated ear drops, syringes, ear wax removal
- **Elastics/Athletic Treatments**
  ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
  Contact lens care
- **Family Planning**
  Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
  Band Aid, 3M Nexcare, non-sport tapes
- **Foot Care Treatment**
  Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles
- **Glucosamine &/or Chondroitin**
  Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements
- **Hearing Aid/Medical Batteries**
- **Home Health Care (limited segments)**
  Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs
- **Incontinence Products**
  Attends, Depend, GoodNites for juvenile incontinence, Prevail
- **Menstrual Products**
- **Nasal Care**
  Saline Nasal Spray
- **Prenatal Vitamins**
  Stuart Prenatal, Nature's Bounty Prenatal Vitamins
- **Reading Glasses and Maintenance Accessories**

<u>Please Note:</u> Currently, the IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs, as they are not prescribed by a physician for a specific ailment.

## Sample List of Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Marriage or Career Counseling
- Swimming Lessons
- Personal Trainers
- Sunscreen (spf less than 30)

*Note: This list is not meant to be all-inclusive.*

# Dependent Care Reimbursement Account - DCRA

## Why Participate?

You can save taxes on costs you incur for care of your dependents so that you can work!

The **Dependent Care Reimbursement Account (DCRA)** allows you to take advantage of current tax laws to pay for these expenses with **pre-tax dollars**. Your tax savings can be significant, but maximizing your benefits requires understanding the plan and some planning.

## *How Does This Work?*

- Elect to make pre-tax payroll contributions into an account, during open enrollment or as a new hire.
- After the plan year begins (or coverage as a new hire), you incur qualifying dependent care expenses.
  - Children under age 13, or
  - Children, dependents or adults over age 13 who are mentally or physically handicapped (incapable of self-care) who live with you and rely on you for financial support.
- Access funds in your account by filing a claim.
  - eFile your claim using your secure Tri-Star account or complete a claim form (see Managing Your Account).
  - Provide a bill from your provider that includes their name, social security number or tax ID number, dates of care and cost.
- Sign up for Direct Deposit for claims reimbursement into your bank account of choice.
- Claims are paid each Friday based on funds already contributed through payroll deduction.

## *Internal Revenue Code Regulations*

- You must enroll each Plan Year to participate.
  - If you are single, or married and filing a joint tax return, you may deposit between $480 & $5,000 from your pay in any year into your DCRA.
  - If you are married and filing a separate tax return, you may deposit between $200 & $2,500 in that year into your DCRA.
- If married, both spouses must be employed and contributions are limited to the income of the lower paid spouse.
- If a spouse is a full-time student, or physically or mentally incapable of self-care, the spouse is deemed to have earned an income of $250/month (if dependent care expenses apply to one dependent) or $500/month (if dependent care expenses apply to two or more dependents).
- Your contributions each pay period must remain the same all year unless you experience a “qualifying change in status event” and change your election, as allowed by the Plan Document.
- Expenses claimed from your account must be incurred during the Plan Year (January 1 - December 31).
- Funds must be claimed by March 31 following the end of each Plan Year. Remaining balances are forfeited.
- You may not claim the Dependent Care Tax Credit on your tax return for expenses reimbursed by this account.
- You must report the name, address and tax ID or social security number of the care provider on Schedule 2441 of your federal tax return.

## Expenses Eligible for Reimbursement

- Child care/babysitting services in your home or someone else's home (as long as the care provider is not another child of yours who is under age 19, or anyone for whom you claim an exemption on your federal income tax return)
- Expenses for a dependent day care center
- Certain expenses for a live-in, full-time housekeeper for a disabled dependent.
- Preschool expenses, up to but not including kindergarten.
- Elder care
- After-school care
- Summer day camp

## Expenses NOT Eligible for Reimbursement

- Child care services provided by your spouse, someone you claim as an exemption on your federal income tax return, or by one of your children under the age of 19
- Housekeeping expenses not related to dependent care
- Dependent care expenses you claim on your federal tax return
- Health care expenses for a dependent
- Food or clothing for a dependent
- Overnight camp, entertainment, activity and book fees.
- Transportation costs between your home and the dependent care center
- Schooling costs for education beginning with kindergarten.

## More Information

**Refer to IRS Publication 503, Child and Dependent Care Expenses at www.irs.gov for more details on potential eligible dependent care expenses.**

**Obtain the Summary Plan Description from your employer for plan specifics on eligibility, termination, changes in status, etc.**

### *Managing Your Account*

You will have a unique secure account with Tri-Star, available on Tri-Star's website **FSA.help/login** where you can:

- File claims & upload documentation,
- Sign up for Direct Deposit for claims payments (***Once established, direct deposit information is retained from year to year.),***
- Update your email address to receive all communications from Tri-Star,
- View previous claims & payments,
- View your available balance.

### *Account Access - Mobile*

You can manage your account from any smart phone or device.

Go to **FSA.help/login** and save the website URL for quick access any time. After you Login:

- Click on the account name/balance,
- File claims,
- Upload Documentation to share your supporting documentation (upload a picture with your phone),
- You'll receive a payment notice via email when your reimbursement is on it's way to you!
- View all claims you have filed against your account,
- See payment details,
- Review your account summary.

Use your profile in the top right corner for more options!

TRI-STAR SYSTEMS

**CLAIMS ADMINISTRATOR:**

16401 Swingley Ridge Road
Suite 250
Chesterfield, MO 63017

Phone: 800-727-0182,
Option 1
www.tri-starsystems.com

16401 Swingley Ridge Road Suite 250 Chesterfield, MO 63017 p 314.576.4022 f 800.818.0829 800.727.0182

# Using My Flexible Spending Account (FSA) Debit Card

**Why would I use the FSA Debit Card?**
The card is a ***payment convenience***, allowing you to use FSA funds to pay medical providers. You may want to use the card to purchase over-the-counter medicines, medical supplies and prescriptions and to pay medical providers (physicians, dentists, vision centers, hospitals, etc.) for qualified expenses. The card COULD eliminate the eliminate the need to provide documentation of the actual services provided to Tri-Star, if your plan includes a fixed copay for the services provided (i.e., Emergency Room, office visits, prescription drugs).

**Where can I use the FSA Debit Card?**
- ***Medical Providers***, e.g., most doctors, hospitals, dentists, optometrists, orthodontists, psychologists, etc.
- ***Inventory Information Approval System (IIAS)*** **Merchants**, e.g., Target, Sav-On Drugs, CVS, etc. These are examples of pharmacies and merchants who sell general merchandise who have installed systems to track qualified FSA eligible items using the product codes. The qualifying expense list is a standard list, adopted by all IIAS members.
- ***Pharmacies or Drug Stores*** that are certified as a "90% merchant," certifying that 90% or more of annual gross sales are for FSA qualified medical items. This list is also posted as noted above for IIAS merchants.
  *All card payments made to these providers will require the detailed statement showing purchase details.*

**When should I *NOT* use my FSA Debit Card?**
*You should never use your card to pay for items that do not qualify for the current FSA plan*, such as:
- Paying a balance due on a service provided prior to the first day of the current FSA plan year;
- Paying for warranties, protection plans on glasses or clip-on sunglasses;
- Paying for expenses that are reimbursed by an insurance plan, an HRA or some other plan;
- Pre-paying for a service that has not yet been provided; or
- Paying for medical expenses if you are in the Health Savings PPO.

*If you pay for non-qualified items with your card, your card could be suspended and you will be required to repay this to your FSA, in compliance with IRS regulations.*

**How do I use the FSA Debit Card?**
Swipe your FSA Debit Card to use as payment at the merchant/physician's card machine and select "credit." This is important since your card does not have a PIN. The card accesses your HCFSA available balance to pay the merchant/physician and correspondingly reduces your HCFSA available balance.

**When should I NOT be asked to provide supporting documentation?**
- **Purchases at IIAS Merchants;**
- **Payments that match the copay** amount for your medical plan (or multiples up to 5 times); and
- **Recurring expenses**, e.g.; orthodontic payments, allergy injections, etc. You must substantiate the first of these each year and should not have to support future payments to the same provider for the same amount during that plan year.

**When WILL I be asked for documentation from Tri-Star?**
You will be asked for documentation when using your card for all expenses other than the reasons listed above. Since most payments to dental and vision providers are not for copays under your employer's plans, you should expect to receive notice from Tri-Star to provide documentation for these payments. Instead of using your card to pay for these, you can file a claim with Tri-Star to receive payment of funds in your account and then pay your provider when you receive their invoice.

**Why do I have to provide documentation if I've used the card?**
IRS regulations require all withdrawals or use of FSA funds to be supported by documentation of the services provided from the independent provider of service or insurance carrier. Additional regulations define what uses of the card can be electronically, automatically substantiated. You will be asked for documentation in situations not considered by the IRS as automatically approved for the HCFSA.

**What information is required that Tri-Star does not already have?**
The credit card system captures and reports only the merchant name, date of payment and payment amount to Tri-Star. The IRS regulations require that supporting documentation include the date the actual services were provided, the patient name a description of the services provided and the charge for services (this may be

different from the amount paid). When responding to Tri-Star's request for additional documentation for items covered by your insurance, you should provide the insurance carrier's Explanation of Benefits (EOB). If the expense was not covered by your insurance you should provide the statement from the physician showing the date the services were provided along with a description of those services, the provider 's name and the charge for the services.

**How do I know when to provide documentation for a transaction?**
You will receive an email from Tri-Star informing you of a new message posted to your online account Message Center. The message in the Message Center includes the transaction(s) requiring supporting documentation, instructions and the corresponding deadline to provide the documentation. You will receive notices via e-mail, to the address you have reported to Tri-Star. To ensure that your e-mail spam filter does not block notices from Tri-Star, you should set up the following e-mail addresses in your address book so they are recognized as trusted addresses:

- *operations@tri-starsystems.com*
- *claims@tri-starsystems.com*

**How can I view the details of my debit card transactions?**
Once you log into your Tri-Star account, you can click on the ***Debit Card*** link on the left menu for approval status of card payments, items awaiting documentation from you, and a list of all card payments.

**Do I have to keep my documentation?**
Yes. Retain all documentation with your tax records, in case of an IRS audit or if requested by Tri-Star.

**How many cards do I get?**
You are issued two cards, both imprinted with the name of the enrolled participant (one to share with a qualified family member also covered under your HCFSA). Each of you should immediately sign the card with your name, agreeing to the terms printed on this card, and activate the card as instructed.

**What if my card is lost or stolen?**
E-mail or call Tri-Star Systems immediately or do this on your online account under the ***Debit Card*** link.
You will pay $5 for each set of cards reissued, which will be deducted from your available HCFSA balance.

**Once I've used all the funds in my account, do I need to keep my card?**
Yes. The physical card itself has an expiration date like any credit or debit card and is valid through this date. You must enroll in the HCFSA during your Annual Enrollment each Plan Year to have funds available on the card. Next year's election will be loaded on this same card, effective at the start of the new Plan Year. *Do not discard your card* or the card company will charge the $5 fee for replacement cards.

**If I don't use the card to pay a provider, can I still file claims for medical expenses I pay personally?** Yes. Each card payment and each physical claim (for items purchased or expenses incurred not paid for using the card), reduce your HCFSA balance. ***Caution: Do not file claims for items you have already paid to providers using your card***.

**If my card does not work at the time I swipe it, what might be wrong?**

- You may have selected the "debit" key instead of "credit." Try this again and select the "credit" button on the machine.
- You may not have funds still available in your HCFSA to cover the amount you are trying to pay with the card. The machine will not accept purchases/payments in excess of your available balance for the Plan Year.
- The merchant may not be identified by the debit/credit card system as a medical provider.
- If you are using the card at a pharmacy or drug store, they may not be an IIAS or 90% merchant.
- Your card will be suspended for overdue documentation requested and you will be required to reimburse the Plan for any reimbursements which still require documentation. Please review card details as noted above under, "***How can I view the details of my debit card transactions?***"

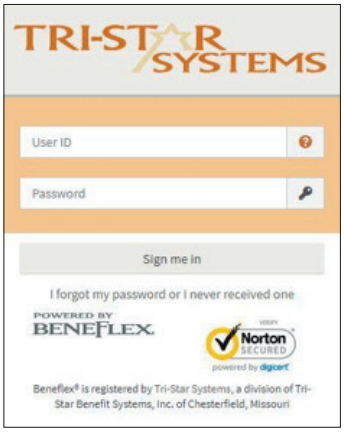
TRI-STAR SYSTEMS
Innovative Employee Benefit Administration Solutions

# Online Account Management

**Each enrolled participant has his own secure personal account, accessible on any computer or mobile device that is connected to the internet. You can view your account any time to check balances and manage account payments and security.**

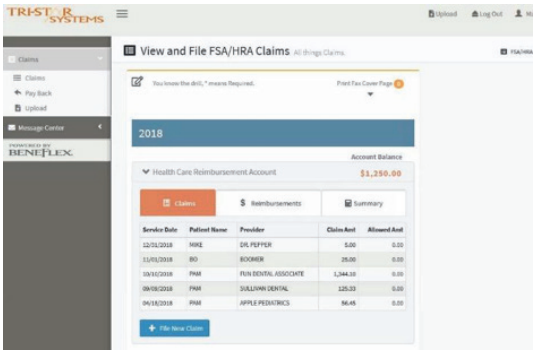
## Go to Tri-Star's Participant Website

1. Enter simply FSA.help/login into your internet browser (desktop or mobile). You are redirected to the secure site login page.
2. As a first-time participant, click on **I forgot my password or I never received one.**
3. Enter your work email address, click Submit.
4. Immediately go to your work email, open Tri-Star's message and click only once on the included link. You will be redirected to the secure login page where you will be asked for personal information provided by your employer to identify you as the user.
5. After successfully providing the matching personal information, you are required to:
   - Set a security question and answer,
   - Set a new strong password, and
   - Establish banking information for deposit of your reimbursements.




**Congratulations! You are now logged in!**

## Claims - View your account(s) by plan year by clicking on the account name.




- **Claims:** any claims already on file on your account are listed
- **File a New Claim:** report a request to be reimbursed for a new expense
  - Don't forget to Upload documentation to support your claim(s)!
    **Using a mobile device with a camera?** You can take/share a picture of your documentation!
  - Need to fax or mail the claim & documentation?
    Click on **Print Fax Cover Page** to create the completed claim form.
- **Reimbursements:** all payments made on the account
- **Summary**: quick overview of your account for the plan year

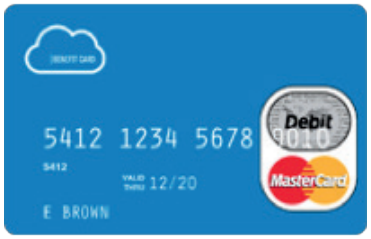
## Ongoing Account Management

- **Click on your name (top right corner) to update**
  - **Profile, to view or change:** 1) Security Question, 2) Password, 3) Contact Information, 4) Email
    Caution: You are welcome to use a personal email address. This will become your User ID to access your account the next time!
  - **Banking:** manage banking information for deposit of your reimbursements
  - **HIPAA:** If you want to authorize Tri-Star to discuss your HIPAA-protected account with someone other than you, please provide the name and relationship of that individual so we can identify and assist him when they call.

TRI-STAR SYSTEMS
Innovative Employee Benefit Administration Solutions

# Online Account Management

## Debit Card




- Debit card status, reporting lost/stolen cards & ordering additional cards
- Transactions approved and denied on your account, including those requiring follow up documentation.
- Have you received notice of an invalid or non-supported card payment(s)?
  You can restore the payment amount to your account using the **Pay Back** link.

## Message Center

Tri-Star cares about the security and privacy of your account information. The Message Center provides important, time-sensitive information about your account and transactions. An email is sent to you notifying you when new messages have been posted to your account.

- A number other than "0" indicates you have unread messages.
- Click on individual messages for details on:
  - Payments Issued
  - Balance Reminders
  - Plan Filing Deadlines
  - Claims Adjusted/Denied
  - Debit Card Documentation Required
  - Debit Card Documentation Received & Approved

  ...and more!

**We are here to assist you!**

**Tri-Star Systems**
16253 Swingley Ridge Road, Suite 210
Chesterfield, MO 63017

800-727-0182, Option 1
Monday – Friday, 7 a.m. – 5 p.m., Central Time
Claims@Tri-StarSystems.com

# SECTION D

## Pharmacy Benefit Information

St. Luke's Pharmacy Frequently Asked Questions

Regarding Prescription Services for St. Luke's Employees

Capital Rx Frequently Asked Questions

Important Notice from St. Luke's Hospital

About your Prescription Drug Coverage and Medicare

St. Luke's PHARMACY

## Frequently Asked Questions Regarding Prescription Services for St. Luke's Employees

St. Luke's Pharmacy is pleased to provide comprehensive, convenient, and confidential filling of prescription medications for you and your family. Through our personalized service, our pharmacy staff will make sure you know exactly what medications you are going to be taking , any potential side effects, as well as when and how to take your medications.

**Why should I get my prescriptions filled through St. Luke's Pharmacy?**
You'll get quick, convenient and personalized service from our experienced pharmacy staff. Our pharmacy staff will counsel you on your medications and discuss any side effects and potential drug interactions. All major insurance plans are accepted and costs are competitive.

**What if I need a new prescription filled or a prescription refilled?**
New prescriptions can be dropped off at the pharmacy, called into the pharmacy by your physician, or sent directly by your physician to St. Luke's Pharmacy via fax or E-scribe. When the retail pharmacy is closed, employees may drop off their prescriptions and refills (along with your contact information and demographic information) at the 3rd floor hospital pharmacy. Prescription refills can be called into St. Luke's pharmacy when needed. St. Luke's offers free mail service, simply call us and tell us that you would like your new prescription(s) and refills mailed to you. Payment must be completed prior to mailing. You are also welcome to pick them up at the retail pharmacy, which is open Monday through Friday from 8 a.m. to 5:30 p.m. and Saturday from 9 a.m. to 12 p.m.

**How do I get my prescriptions transferred to St. Luke's Pharmacy (prescription was originally filled at another pharmacy)?**
If you would like to transfer any or all of your prescriptions to St. Luke's Pharmacy, we are happy to call your existing pharmacy and take care of it for you. We will need your name, medication and prescription number if available.

**I work night shift, how will I obtain my prescriptions?**
For the convenience of our evening and night shift employees, prescriptions may be picked up at our 3rd floor hospital pharmacy. This will need to be pre-arranged and pre-paid by calling our retail pharmacy staff at 314-205-6023. Please note that only prescriptions that are pre-arranged to be picked up that evening will be available at our hospital pharmacy.
St. Luke's Pharmacy also offers free mail service. Simply call us and tell us you would like your new prescription(s) and refills mailed to you. Payment must be completed prior to mailing. You are also welcome to pick them up at the retail pharmacy, which is open Monday through Friday from 8 a.m. to 5:30 p.m. and Saturday from 9 a.m. to 12 p.m.

**I work off site, how will I obtain my prescriptions?**
St. Luke's Pharmacy offers free mail service. Simply call us and tell us you would like your new prescription(s) and refills mailed to you. Payment must be completed prior to mailing. You are also welcome to pick them up at the retail pharmacy, which is open Monday through Friday from 8 a.m. to 5:30 p.m. and Saturday from 9 a.m. to 12 p.m. Delivery service to Des Peres Pharmacy is available for employees at Des Peres Hospital. Please call the retail pharmacy for more details.

**My child is away at college, how will I obtain their prescriptions?**
St. Luke's Pharmacy offers free mail service. Simply call us and tell us you would like your new prescription(s) and refills mailed to you. Payment must be completed prior to mailing. You are also welcome to pick them up at the retail pharmacy, which is open Monday through Friday from 8 a.m. to 5:30 p.m. and Saturday from
9 a.m. to 12 p.m.

**Will employees be able to use Payroll deduction at the Pharmacy?**
Employee payroll deduction is available at the Retail pharmacy. In order to utilize this benefit you must have completed and returned to Human Resources- Request for Cashless System Payroll deduction form.

**Employee Savings -Mail Order (90 day supply) prescriptions.**
90-day supply refills are available at St. Luke's at 2 times the normal monthly co-pay while at other pharmacies it will cost 2.5 times the normal monthly co-pay plus an additional amount based on drug category. Save both time and money by using your St. Luke's pharmacy!

**Employee Savings -Prescription Refills.**
Copays for Prescription refills at St. Luke's Pharmacy will cost less than using outside Retail Pharmacies. See benefit plans. Save both time and money by using your St. Luke's pharmacy!

**What if I have a question for the pharmacist of a confidential nature?**
If needed, the pharmacy has a separate room dedicated for consultation and education. We take privacy very seriously.

**How can I be assured that my information will be kept confidential?**
St. Luke's pharmacy is committed to keeping all health information private. All prescription information will be handled with the utmost confidentiality and professionalism.

**I have more questions. Who should I contact?**
We would be happy to answer any questions you might have. Please call Amy Cohron directly at the St. Luke's location.

**Where is the Pharmacy located and what are their hours?**
St. Luke's Pharmacy is conveniently located at:

**St. Luke's Pharmacy**
224 S. Woods Mill Rd. Suite 350
Chesterfield, MO 63017
Monday through Friday
8 a.m. to 5:30 p.m.
Saturday
9 a.m. to 12 p.m.
314-205-6023
314-205-6496 (fax)

# Pharmacy Benefit Frequently Asked Questions

Capital Rx

Outlined below are some questions and answers to help you better navigate your pharmacy benefit offered to you by Capital Rx, your prescription benefit provider. For additional questions, please contact your dedicated Customer Care team at 1-888-302-2779. We are available 24 hours a day, 7 days a week to answer any questions you may have about your prescription benefit plan.

## Who is Capital Rx?

**Answer:** Capital Rx is a next generation pharmacy benefit manager, overseeing prescription benefit plans on behalf of employers and you - our members. We work hard every day to ensure your prescription plan is cost effective while never losing sight of our ultimate mission: your health. Check out our video to learn more about who we are!

## What is a Pharmacy Benefit Manager (PBM)?

**Answer:** A pharmacy benefit manager (PBM) processes prescription drug claims on behalf of you and your plan sponsor (usually your employer, union, etc.). To provide this service, we contract and negotiate with retail pharmacies and pharmaceutical manufacturers to provide the right balance of drug access and cost-effectiveness.

## Can I still fill my prescriptions at my preferred pharmacy with Capital Rx?

**Answer:** Capital Rx maintains a national network of more than 60,000 pharmacies, including all national chains and most independent pharmacies. However, with some prescription benefit plans, certain pharmacies may be excluded from the network. To confirm the network status of your preferred pharmacy, please log in to our member portal and click on Nearby Pharmacies to find a pharmacy near you. Once you arrive at the pharmacy, don't forget to show the pharmacist your ID card to ensure you only pay the out-of-pocket cost associated with your prescription benefit plan. For any additional questions, please contact Capital Rx at **1-888-302-2779**.

## Is my current (or new) prescription covered by Capital Rx?

**Answer:** Your coverage for each prescription drug is outlined on our formulary (i.e., preferred drug list). Although most prescription benefit plans use one of our normal formularies, some plan sponsors require customization to best serve the needs of their membership. To confirm the coverage status of a medication - including if a prior authorization, step therapy, or quantity limit applies - please consult the formulary specific to your prescription benefit plan by logging into our member portal to learn more about copays and coverage information.

# Pharmacy Benefit Frequently Asked Questions

## How do I know what my out-of-pocket cost (i.e., copay or coinsurance) will be with Capital Rx?

**Answer:** You can easily view expected medication cost by logging into the member portal and click the best price icon. Enter the name of the medication in the drug name field. Define specific options using the drop downs for type, form, dosage, and quantity. Click on the find lowest price icon. A list of local pharmacies will be provided along with the expected cost for the specified medication.

## How do I request reimbursement for my pharmacy claim if it did not process through my pharmacy benefit?

**Answer:** If for any reason you were unable to apply your prescription benefit to fill a prescription, you can make a request for reimbursement by completing our Direct Member Reimbursement (DMR) form and mailing it to the below address, along with the original receipt from the pharmacy (please make a copy for your own records). It is important that you provide us with as much detail as possible so that we can process your claim appropriately for reimbursement. Depending on your plan's elections, you may be reimbursed directly for covered prescriptions. Blank DMR forms are available by visiting our website or by logging into the member portal.

Capital Rx, Inc.
Attn: Claims Department
9450 SW Gemini Dr., Suite 87234
Beaverton, OR 97008

## Is mail order delivery right for me? If so, how do I enroll?

**Answer:** If you have a prescription for a maintenance medication (i.e., long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol), mail order delivery may be a great solution for you. You will find mail order provides greater savings on most prescription benefit plans and saves time typically spent traveling and waiting at a retail pharmacy. You can also fill these prescriptions at St. Luke's Pharmacy.

St. Luke's Pharmacy
South Medical Building, Suite 350
Chesterfield, MO 63017
Phone: 314-205-6023
Hours: Monday – Friday 8am to 5:30pm
Saturday 9am to 12pm

## Getting started with Optum Home Delivery:

Please reach out to your prescriber and update your mail order pharmacy provider to Optum Home Delivery.

Online: Go to the Capital Rx member portal to register or log in. Select 'Home Delivery' to confirm your profile settings.

Phone: Call **1-888-302-2779** and follow the prompts for 'medications delivered to your home' or ask your doctor to send an electronic prescription to Optum Home Delivery. A coordinator will reach out to get you set up.

# Pharmacy Benefit Frequently Asked Questions

## Choose one of the following options to request refills of current prescriptions or to send new prescriptions to Optum Home Delivery

E-prescribe(preferred): Have your prescriber electronically send your prescription to Optum Home Delivery.

Fax: Have your prescriber fax your prescription to Optum Home Delivery. Faxed prescriptions may only be sent by a doctor's office and must include patient information.

Online (Refills Only): Log in to the Capital Rx member portal to place an order for available refills.

Mail: Mail your paper prescription to Optum Home Delivery at 6800 W. 115th St., Suite 600, Overland Park, KS. 66211-9838.

## How do I check the order status of my mail order and/or Specialty medications?

**Answer:** You can check your order status by logging into the Capital Rx member portal and selecting 'Home Delivery' or 'Specialty Pharmacy'. Select 'Order Status'. If you prefer, you can check your order status by calling Capital Rx Customer Care at **1-888-302-2779.**

## How do I fill my Specialty medication?

**Answer:** If you are prescribed a specialty medication, you can get specialty medications at either St Luke's Retail Pharmacy or Optum Specialty Pharmacy. For additional specialty pharmacy questions, please call your dedicated Capital Rx Customer Care team at **1-888-302-2779** or call the St Luke's Retail Pharmacy at **314-205-6023** between 8:30am and 5:30pm CT Monday through Friday.

Online: Go to the Capital Rx member portal to register or log in. Select 'Specialty Pharmacy'. Fill out the New Patient Form, and we will take it from there.
Phone: Call Capital Rx Customer Care and follow the prompts for 'specialty pharmacy' or ask your doctor to send an electronic prescription to Optum Specialty Pharmacy.

A patient care coordinator may reach out for more information to finalize your account or set up your first order. We will also contact your provider for an up-to-date prescription, if needed.

If your prescription needs a prior authorization, your prescriber may need to take extra steps to submit your prescription. To read more about prior authorizations, visit https://cap-rx.com/members/ or call Capital Rx Customer Care.

## What if I need to fill a prescription and don't have my physical ID card at the pharmacy?

**Answer:** You can provide the pharmacy with your member ID and the following information. This should be all they need to process the claim.

RxBIN: 610852
RxPCN: CHM
RxGroup: JD158

If the pharmacy is still unable to process, you can have them contact Capital Rx at **1-888-302-2779** or download a temporary pharmacy ID card on the website or mobile app.

# Pharmacy Benefit Frequently Asked Questions

## How do I replace a lost ID card?

**Answer:** To request a replacement ID card, please call UMR for support.

## What retail pharmacies are considered in-network with Capital Rx?

**Answer:** You can locate an in-network pharmacy by logging into our member portal. Select Member Login to register. Use the pharmacy locator search tool to view local options. You can also call your dedicated Customer Care team at **1-888-302-2779** for support.

## What if I need to change retail pharmacies but I have an existing prescription?

**Answer:** Once you locate an in-network retail pharmacy, you can work with the new pharmacy to transfer your existing prescription. Contact the retail pharmacy you wish to change to and be prepared with the following information:

- Name and phone number of your previous pharmacy
- Prescription name and number from your medication label
- Capital Rx processing information

Please note: Prescriptions that are expired, have zero refills remaining or are for controlled substances are not eligible for transfer. Please work with your prescriber to request a replacement prescription to be sent to your new retail pharmacy.

## What is a Prior Authorization (PA)?

**Answer:** A prior authorization (PA) is a feature of your prescription benefit plan that requires you and your physician to obtain approval before the prescribed medication can be dispensed by a retail or mail order pharmacy. This requirement exists to prevent inappropriate prescribing of certain medications and to ensure the lowest cost alternative is used (barring medical necessity). To submit a prior authorization (if required) please have your prescriber complete the prior authorization request form and fax it (along with any additional documentation required) to 1-833-434-0563. Your prescriber can download a blank form by visiting our website. Most prior authorization reviews are completed within two business days provided that a complete prior authorization request form and all required documentation are correctly submitted. Our clinical team will notify your prescriber in advance of any declinations and assist in expediting you to a preferred alternative therapy. Prior authorization request forms can also be sent via mail to the below address:

Capital Rx, Inc.
Attn: Prior Authorization Department
9450 SW Gemini Dr., Suite 87234
Beaverton, OR 97008

For additional prior authorization questions, please call your dedicated Customer Care team at **1-888-302-2779** or the Prior Authorization department at 1-888-952-2779.

# Pharmacy Benefit Frequently Asked Questions

## What is a Step Therapy (ST)?

**Answer:** A step therapy (ST) is a feature of your prescription benefit plan that requires you try another medication (usually a generic) before being prescribed the medication designated with step therapy (usually a brand). This requirement exists to prevent inappropriate prescribing of certain medications and to ensure the lowest cost alternative is used. If your physician prescribes, or wants to prescribe, a medication designated with step therapy, please have them call our Customer Care team **1-888-302-2779.**

## What is a Quantity Limit (QL)?

**Answer:** A quantity limit (QL) is a feature of your prescription benefit plan that only allows you to receive up to a maximum dosage or quantity for certain medications (e.g., opioids). Quantity limit requirements exist to ensure safe and effective doses are prescribed and to prevent waste, fraud, and abuse. If you and your physician require a dose or quantity beyond what the quantity limit allows, please submit a prior authorization, including medical justification for the larger dose or quantity.

## What happens if I am diabetic and use a meter and glucose strips?

**Answer:** Capital Rx allows coverage of meters and glucose strips through Contour. Contour provides a free meter and a variety of glucose strips. If you need assistance in getting set up for your diabetic supplies through Contour, contact Capital Rx at **1-888-302-2779**.

## How do I authorize a family member or care giver to manage my pharmacy benefits?

**Answer:** A Personal Health Information Disclosure form is available to allow members to manage and access your pharmacy benefits. You can complete this form digitally by visiting our website and scroll to locate the Personal Health Information Disclosure Form link. If you prefer, you can download the form and mail it back to the address below. To download a blank form, open the form with the click here button. At the top, left hand corner of the screen select options and Download PDF.

Capital Rx, Inc.
Attn: Customer Care
9450 SW Gemini Dr., Suite 87234
Beaverton, OR 97008

## What formulary has St Luke's Hospital selected and where can I find what medications are on it?

**Answer:** St Luke's Hospital has selected the Capital Rx Liberty Formulary. This list of drugs is covered by your pharmacy prescription benefit, however, there are some drugs on this list that display as covered on the formulary but may not be covered if your plan does not include coverage of certain categories. If you have any questions regarding your specific coverage, please call your dedicated Customer Care team **1-888-302-2779.**

# Important Notice from St. Luke's Hospital 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. Luke's Hospital 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. Luke's Hospital has determined that the prescription drug coverage offered by the St. Luke's Health Plans 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.**

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## When Can You Join A Medicare Drug Plan?

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

## 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. Luke's Hospital coverage will not be affected. Following is an outline of your St. Luke's coverage:

| | | St. Luke's Basic Plan | St. Luke's Premium Plan | St. Luke's HDHP Plan |
|---|---|---|---|---|
| **Retail/30** | Generic Tier 1 and First fill only Tier 2-3 | $12 | $10 | OOP Max |
| | Generic Tier 2-3 refills | $18 | $15 | OOP Max |
| | Brand Tier 1 and first fill only Tier 2-3 | $25 | $25 | OOP Max |
| | Brand Tier 2-3 refills | $30 | $30 | OOP Max |
| | Non-Pref Brand Tier 1 and first fill only Tier 2-3 | $50 | $50 | OOP Max |
| | Non-Pref Brand Tier 2-3 refills | $75 | $75 | OOP Max |
| | Specialty/30 | Copay $150 | | |

| | | | | |
|---|---|---|---|---|
| **Mail /90** | Generic Tier 1 and first fill only Tier 2-3 | $24 | $20 | OOP Max |
| | Generic Tier 2-3 refills | $36 | $30 | OOP Max |
| | Brand Tier 1 and first fill only Tier 2-3 | $50 | $50 | OOP Max |
| | Brand Tier 2-3 refills | $67.50 | $67.50 | OOP Max |
| | Non-Pref Brand Tier 1 and first fill only Tier 2-3 | $100 | $100 | OOP Max |
| | Non-Pref Brand Tier 2-3 refills | $187 | $187 | OOP Max |

If you do decide to join a Medicare drug plan and drop your current St. Luke's coverage, be aware that you and your dependents may not be able to get this coverage back.

## 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. Luke's 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 This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or contact the St. Luke's Benefit Department at (314) 205-6016. **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. Luke's changes. You also may request a copy of this notice at any time.

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

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

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

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

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

| | |
|---|---|
| ***Date:*** | October 2023 |
| ***Name of Sender:*** | St. Luke's Hospital |
| ***Contact:*** | Benefits Office |
| ***Address:*** | 230 S. Woods Mill Rd, Ste. 230 SMOB<br>Chesterfield, MO 63017 |
| ***Phone Number:*** | (314) 205-6016 |

# SECTION E

## CONTINUATION OF COVERAGE

Frequently Asked Questions about your

Continuation of Coverage

St. Luke's Continuation of Coverage

Enrollment Form for 2024

New Health Insurance Marketplace

Coverage Options and your Health Coverage

## Frequently Asked Questions
## About Your Continuation of Coverage

### What is Continuation of Coverage?

If you or your dependent(s) become ineligible for group health coverage, you may be able to continue medical, dental or vision coverage for a period of time. Continuation of Coverage is available only if you or your dependents had coverage under the active plan immediately prior to the qualifying event date (the date you or your dependent lost coverage under the active plan). Please contact Human Resources if you're unsure about whether you or your covered dependents can elect Continuation of Coverage.

### How long will Continuation of Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, the employee's becoming entitled to Medicare benefits or divorce, coverage may be continued for up to a total of 36 months.

Continuation of Coverage will be terminated before the end of the maximum period if:

- You fail to pay the required monthly premium by the "Due Date". ("Due Date" is defined as the first day prior to the month for which coverage is to be continued);
- You become covered, after electing continuation coverage, under any group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition you may have;
- You become entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- It is determined under the Social Security Act that you are no longer disabled.
- St. Luke's no longer provides any group health plan coverage for any of its employees.

Continuation of Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### How can you extend the length of Continuation of Coverage?

If you elect Continuation of Coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. You must notify Human Resources of a disability during the first 60 days of Continuation of Coverage, and the disability must be certified within the first 18 months, you or your covered dependent(s) may continue coverage up to 29 months from the original continuation effective date. Failure to provide notice of a disability may affect the right to extend the period of Continuation of Coverage.

**How can you elect Continuation of Coverage?**

To elect Continuation of Coverage, you must complete the St. Luke's Continuation of Coverage Enrollment Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect Continuation of Coverage. For example, the employee's spouse may elect Continuation of Coverage even if the employee does not. Continuation of Coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect Continuation of Coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Continuation of Coverage, you should take into account that you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of Continuation of Coverage.

**How much does Continuation of Coverage cost?**

Please see the enrollment form for Continuation of Coverage rates.

**When and how must payment be made for Continuation of Coverage?**

The monthly premium amount, payable to St. Luke's Hospital, by Check, Money order or Credit card is **due prior to the first of each month**. It is your responsibility to send this payment on a monthly basis. You will not be billed or contacted in regard to payments. Failure to make timely payments will result in cancellation of your coverage. Your first month of coverage may be prorated based on the number of days remaining in the first month of coverage. **Please note automatic bill pay is not an acceptable form of payment.** Your enrollment form and premium payment should be sent to:

St. Luke's Hospital
Attn: Benefit Representative-Human Resources
232 S. Woods Mill Road, Ste. 230 SMOB
Chesterfield, MO 63017

The amount due for each coverage period for each qualified beneficiary is shown in this notice. If you make a payment prior to the first day of the month, your coverage under the Plan will continue for that coverage period without any break. St. Luke's will not send notices of payments due for these coverage periods. Your Continuation of Coverage will be terminated if payment is not received in the office **prior to the first day of the month for which coverage is provided**.

**Keep Your Plan Informed of Address Changes**

In order to protect you and your family's rights, you should keep the Benefits Office informed of any changes in your address and the addresses of family members. You should also keep a copy for your records, of any notices you send to the Benefits Office.

**Continuation of Coverage (Health Insurance Marketplace):**

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

There may be other coverage options for you and your family. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions about your rights to continuation coverage, you should contact the Benefits Office at 314-205-6016.

# St. Luke's Continuation of Coverage Enrollment Form 2024

Name _____EMP. ID#_____ Phone _____

Date of Birth _____ Last 4 Social Security # _____

Street Address _____ Email _____

City / State / Zip Code _____

You are only eligible to continue existing benefit coverage up to the dollar amounts shown below:

| | Basic Medical | Premium Medical | HDHP Medical | Basic Dental | Premium Dental | Basic Vision | Premium Vision |
|---|---|---|---|---|---|---|---|
| Employee | $777.25 | $863.61 | $715.56 | $32.74 | $49.51 | $5.39 | $10.34 |
| Employee + Spouse | $1,709.95 | $1,899.93 | $1,574.21 | $72.04 | $108.95 | $10.77 | $20.71 |
| Employee + Children | $1,399.04 | $1,554.49 | $1,287.99 | $58.94 | $89.13 | $11.53 | $22.15 |
| Family | $2,487.20 | $2,763.54 | $2,289.77 | $104.78 | $158.46 | $18.42 | $35.41 |

**Participant Information: For each participant place an "X" in the appropriate column of desired insurance coverage.**

| Name | SSN | DOB | Sex | Medical | Dental | Vision |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

I, _____, hereby request continuation of my insurance coverage as indicated above. I understand that I am responsible for paying the full cost of coverage, and premiums will be retroactive to the effective date of coverage and payments are **due prior to the first of each month**. **Automatic bill pay is not an accepted form of payment.** I understand that if I fail to pay any premium on time, the coverage will automatically terminate and will not be reinstated. I also understand that I am responsible for notifying St. Luke's Human Resources if I become ineligible for continuation of coverage as outlined in the notification letter and Benefit Summary booklet. I certify that the information provided on this form is true and correct.

Signature_____ Date _____

This form and first payment must be received within 60 days from your date of separation:

**St. Luke's Hospital, Human Resources**
**232 S. Woods Mill Road, 230 SMOB**
**Chesterfield, MO 63017**
**slhstlukesemployeebenefits@stlukes-stl.com**

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact St. Luke's benefits office at 314-205-6016.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

# PART B: Information About Health Coverage Offered by Your Employer

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

| 3. Employer name | 4. Employer Identification Number (EIN) |
|---|---|
| St. Luke's Hospital | 43-0652680 |
| 5. Employer address | 6. Employer phone number |
| 232 South Woods Mill Rd | 314-434-1500 |

| 7. City | 8. State | 9. ZIP code |
|---|---|---|
| Chesterfield | MO | 63017 |

10. Who can we contact about employee health coverage at this job?
St. Luke's benefits office 314-205-6016

| 11. Phone number (if different from above) | 12. Email address |
|---|---|
| | slhstlukesemployeebenefits@stlukes-stl.com |

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Those employees of the employer who satisfy the eligibility requirements under the health plan, which include among other items, any required waiting periods and minimum hours of work. Please consult the Benefits Summary Book or contact the Human Resources Department for more information.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Those individuals who have a prescribed relationship with an eligible employee of the employer and satisfy the eligibility requirements under the health plan. Consult the Benefits Summary Book or contact the Human Resources Department for more inforamtion.

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

# Need Medicare Insurance Assistance? Here's Help.

As you approach age 65 and Medicare eligibility, we are taking this opportunity to share some important information about Medicare with you so you can be aware and educated about your options at St. Luke's Hospital.

St. Luke's Hospital offers a variety of helpful and free Medicare insurance resources, made available by MedicareCompareUSA*. MedicareCompareUSA agents represent St. Luke's Hospital and its accepted Medicare plans (including Medicare Advantage, Medicare Supplements and Medicare Prescription plans) and always makes sure patients receive unbiased information on those plans.

Medicare Plan Comparison Helpline
St. Luke's Hospital participates with several Medicare Advantage plans and we accept all forms of Medicare supplemental insurance. St. Luke's also bills most employer-sponsored Medicare plans as a courtesy to the patient. Before signing up for a Medicare Advantage plan, please be sure to verify with the insurance company that St. Luke's Hospital physicians are part of their provider network. Call the Medicare Plan Comparison and Enrollment Center at 855-256-1498 to get started.

- Verify Medicare plans accepted by your healthcare providers
- Compare Medicare plans to meet your personal needs and preferences
- Identify a Medicare prescription plan that covers all your medications at the lowest cost
- Assistance throughout the Medicare plan enrollment process

Medicare Patient Questionnaire
We request that all patients approaching age 65 take a few moments to complete a Medicare Patient Questionnaire. The information you provide helps us prepare to better serve you as you transition to Medicare. The questionnaire also provides information regarding helpful resources St. Luke's Hospital provides for our Medicare patients and the community. Access the questionnaire and submit your responses online.

*MedicareCompareUSA is a Medicare-specialty insurance agency not affiliated with the federal Medicare program. Services of MedicareCompareUSA are offered at no cost; MedicareCompareUSA is compensated directly by whichever Medicare plan is chosen by the Medicare beneficiary.

# SECTION F

## BENEFIT NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

Women's Health & Cancer Right Act

Newborns' & Mothers' Health Protection Act

Notice of Privacy Practices

Discrimination is Against the Law

Medical SBCs

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website:<br>https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |

| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |

| WISCONSIN – Medicaid and CHIP | WYOMING – Medicaid |
|---|---|
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

## Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

**Women's Health & Cancer Rights Act**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plans.

**Newborns' & Mothers' Health Protection Act**

The Newborns' and Mothers' Health Protection Act requires a minimum length of hospital confinement in conjunction with childbirth. Coverage for a hospital stay following a normal delivery may not be limited to less than 48 hours for both the mother and newborn, and for a cesarean section, not less than 96 hours. However, this does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plans.

# Notice of Privacy Practices

# Medical, Dental, and Vision Plans for the Employees of St. Luke's Hospital

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

### Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes , except that we may use your health information for marketing for limited situations as allowed by law
  *Example: We may inform you about changes in our provider networks, changes to your health plans or health-related products or services.*
- Sale of your information

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you.
  *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  *Example: We use health information about you to develop better services for you.*

**Pay for your health services**

- We can use and disclose your health information as we pay for your health services.
  *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

- We may disclose your health information to your health plan sponsor for plan administration.
  *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

### How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
  www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

- We can use or share your information for health research.

**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Business Associates**

- We may share your health information with certain individuals and companies that we contract with to perform functions for us. We require these individuals and companies to protect your information and keep it confidential.
  *Example: We share information with a billing company to help us with some of our premium billings.*

**Another Health Plan and Your Employer**

- Information may be disclosed to another health plan maintained by St. Luke's Hospital for purposes of facilitating claims payments under that plan.
- For the purpose of administering the plans, information may be disclosed to certain employees of St. Luke's Hospital. However, we will not share information with your employer for purposes of obtaining family medical leave coverage or for job related activities, such as promotion or firing, without your written permission.

**Stop-Loss Insurance**

- We may share your health information with our stop-loss carrier to pay claims or rate premiums.

**State Law**

- When your state's laws have more strict requirements for privacy or security of your protected health information than federal law, we will follow state law.
  *Example: Missouri law requires that we get your written permission before we share particularly sensitive information such as HIV/AIDS status. We will get your authorization before we share this type of information.*

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

## Other Instructions for Notice

- This notice is effective September 23, 2013
- If you have any questions about this notice, please contact the Human Resources Department at 314-205-6016.

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $400 person / $450 family Tier 1<br>$1,200 person / $3,240 family Tier 2<br>$3,000 person / $5,120 family Tier 3 | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | $1,650 person / $3,450 family Tier 1<br>$5,780 person / $13,520 family Tier 2<br>$10,000 person / $18,800 family Tier 3 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out–of–pocket limit?** | Penalties, premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |
|  | All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 Copay per visit; Deductible Waived | $15 Copay per visit; Deductible Waived | 50% Coinsurance | None |
| | Specialist visit | $20 Copay per visit; Deductible Waived | $20 Copay per visit; Deductible Waived | 50% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | No charge; Deductible Waived | No charge; Deductible Waived physician all ages; 50% Coinsurance; Deductible Waived facility to age 18; 50% Coinsurance facility from age 18 | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; Deductible Waived office setting; 15% Coinsurance outpatient setting | No charge; Deductible Waived office setting; 35% Coinsurance outpatient setting | 50% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| | Imaging (CT/PET scans, MRIs) | No charge; Deductible Waived office setting; 15% Coinsurance outpatient setting | No charge; Deductible Waived office setting; 35% Coinsurance outpatient setting | 50% Coinsurance | None |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at https://app.cap-rx.com/login | Generic drugs (Tier 1) | **30-day supply** - $12.00<br>**> 30-day supply** - $24.00 | **30-day supply** - $18.00<br>**> 30-day supply** - $36.00 | **30-day supply** $18.00<br>**> 30-day supply** - $36.00 | The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs (Tier 3), as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. Prescription drugs considered non-formulary are not covered. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office or call Capital Rx Customer Care at 1-888-302-2779. |
| | Preferred brand drugs (Tier 2) | **30-day supply** - $25.00<br>**> 30-day supply** - $50.00 | **30-day supply** - $30.00<br>**> 30-day supply** - $67.50 | **30-day supply** - $30.00<br>**> 30-day supply** - $67.50 | |
| | Non-preferred brand drugs (Tier 3) | **30-day supply** - $50.00<br>**> 30-day supply** - $100.00 | **30-day supply** - $75.00<br>**> 30-day supply** - $187.00 | **30-day supply** - $75.00<br>**> 30-day supply** - $187.00 | |
| | Specialty drugs (Tier 4) | **All fills** - $150 | **All fills** - $150 | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | None |
| | Physician/surgeon fees | 15% Coinsurance | 15% Coinsurance | 50% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you need immediate medical attention** | Emergency room care | $250 Copay per visit; Deductible Waived | $250 Copay per visit; Deductible Waived | $250 Copay per visit; Deductible Waived | Copay may be waived if admitted |
| | Emergency medical transportation | 15% Coinsurance | 15% Coinsurance | 15% Coinsurance | Tier 1 deductible applies to Tier 2 & 3 benefits |
| | Urgent care | $35 Copay per visit; Deductible Waived | $50 Copay per visit; Deductible Waived | 50% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Physician/surgeon fees | 15% Coinsurance | 15% Coinsurance | 50% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $15 Copay per visit; Deductible Waived office visits; 15% Coinsurance other outpatient services | $15 Copay per visit; Deductible Waived office visits; 35% Coinsurance facility; 15% Coinsurance physician other outpatient services | 50% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician other outpatient services |
| | Inpatient services | 15% Coinsurance | 35% Coinsurance facility; 15% Coinsurance physician | 50% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | 50% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 15% Coinsurance | 15% Coinsurance | 50% Coinsurance | |
| | Childbirth/delivery facility services | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | 90 Maximum visits in a 12 month period; Preauthorization is required. |
| | Rehabilitation services | $15 Copay per visit PCP; $20 Copay per visit Specialist; Deductible Waived office therapy; 15% Coinsurance hospital therapy | $15 Copay per visit PCP; $20 Copay per visit Specialist; Deductible Waived office therapy; 35% Coinsurance hospital therapy | 50% Coinsurance | 60 Maximum visits per calendar year |
| | Habilitation services | | | | |
| | Skilled nursing care | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | Preauthorization is required. |
| | Durable medical equipment | 25% Coinsurance | 25% Coinsurance | 50% Coinsurance | Tier 2 deductible applies to Tier 1 benefits; Preauthorization is required for DME in excess of $500 for rentals or purchases. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| | Hospice service | 15% Coinsurance | 35% Coinsurance | 50% Coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | $15 Copay per visit PCP; $20 Copay per visit Specialist; Deductible Waived | $15 Copay per visit PCP; $20 Copay per visit Specialist; Deductible Waived | 50% Coinsurance | 1 Maximum exam per calendar year |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Private-duty nursing (Outpatient care)
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**Does this plan Provide Minimum Essential Coverage? Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan Meet the Minimum Value Standard? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist copayment** | **$20** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $0 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,710** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist copayment** | **$20** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $400 |
| Copayments | $900 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,400** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist copayment** | **$20** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $400 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

# UMR: ST LUKE'S HOSPITAL: 7670-02-410532 002



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $200 person / $450 family Tier 1<br>$600 person / $1,500 family Tier 2<br>$1,500 person / $2,200 family Tier 3 | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | $1,250 person / $2,000 family Tier 1<br>$3,700 person / $7,000 family Tier 2<br>$6,325 person / $11,360 family Tier 3 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out–of–pocket limit?** | Penalties, premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |
|  | All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 Copay per visit; Deductible Waived | $10 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Specialist visit | $15 Copay per visit; Deductible Waived | $15 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | No charge; Deductible Waived | No charge; Deductible Waived physician all ages; 40% Coinsurance; Deductible Waived facility to age 18; 40% Coinsurance facility from age 18 | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; Deductible Waived office setting; 10% Coinsurance outpatient setting | No charge; Deductible Waived office setting; 25% Coinsurance outpatient setting | 40% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| | Imaging (CT/PET scans, MRIs) | No charge; Deductible Waived office setting; 10% Coinsurance outpatient setting | No charge; Deductible Waived office setting; 25% Coinsurance outpatient setting | 40% Coinsurance | None |
| **If you need drugs to treat your illness or condition.** More information about prescription drug coverage is available at https://app.cap-rx.com/login. | Generic drugs (Tier 1) | **30-day supply** - $10.00 **> 30-day supply** - $20.00 | **30-day supply** - $15.00 **> 30-day supply** - $30.00 | **30-day supply** - $15.00 **> 30-day supply** - $30.00 | Prescription Drugs. The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs (Tier 3), as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. Prescription drugs considered non-formulary are not covered. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office or call Capital Rx Customer Care at 1-888-302-2779. |
| | Preferred brand drugs (Tier 2) | **30-day supply** - $25.00 **> 30-day supply** - $50.00 | **30-day supply** - $30.00 **> 30-day supply** - $67.50 | **30-day supply** - $30.00 **> 30-day supply** - $67.50 | |
| | Non-preferred brand drugs (Tier 3) | **30-day supply** -$50.00 **> 30-day supply** - $100.00 | **30-day supply** - $75.00 **> 30-day supply** - $187.00 | **30-day supply** - $75.00 **> 30-day supply** - $187.00 | |
| | Specialty drugs (Tier 4) | **All fills** - $150 | **All fills** - $150 | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | None |
| | Physician/surgeon fees | 10% Coinsurance | 10% Coinsurance | 40% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon |
| **If you need immediate** | Emergency room care | $250 Copay per visit; Deductible Waived | $250 Copay per visit; Deductible Waived | $250 Copay per visit; Deductible Waived | Copay may be waived if admitted |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **medical attention** | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | 10% Coinsurance | Tier 1 deductible applies to Tier 2 & 3 benefits |
| | Urgent care | $20 Copay per visit; Deductible Waived | $35 Copay per visit; Deductible Waived | 40% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Physician/surgeon fees | 10% Coinsurance | 10% Coinsurance | 40% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $10 Copay per visit; Deductible Waived office visits; 10% Coinsurance other outpatient services | $10 Copay per visit; Deductible Waived office visits; 25% Coinsurance facility; 10% Coinsurance physician other outpatient services | 40% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician other outpatient services |
| | Inpatient services | 10% Coinsurance | 25% Coinsurance facility; 10% Coinsurance physician | 40% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | 40% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| | Childbirth/delivery professional services | 10% Coinsurance | 10% Coinsurance | 40% Coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | 90 Maximum visits in a 12 month period; Preauthorization is required. |
| | Rehabilitation services | $10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived office therapy; 10% Coinsurance hospital therapy | $10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived office therapy; 25% Coinsurance hospital therapy | 40% Coinsurance | 60 Maximum visits per calendar year |
| | Habilitation services | | | | |
| | Skilled nursing care | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Durable medical equipment | 15% Coinsurance | 15% Coinsurance | 40% Coinsurance | Tier 2 deductible applies to Tier 1 benefits; Preauthorization is required for DME in excess of $500 for rentals or purchases. |
| | Hospice service | 10% Coinsurance | 25% Coinsurance | 40% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If your child needs dental or eye care** | Children's eye exam | $10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived | $10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived | 40% Coinsurance | 1 Maximum exam per calendar year |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Private-duty nursing (Outpatient care)
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**Does this plan Provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan Meet the Minimum Value Standard?** **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$200** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $0 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$1,310** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$200** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $200 |
| Copayments | $900 |
| Coinsurance | $70 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,190** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$200** |
| **Specialist copayment** | **$15** |
| **Hospital (facility) coinsurance** | **10%** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $200 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

# UMR: ST LUKE'S HOSPITAL: 7670-02-410532 003



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,700 person / $3,200 family Tier 1<br>$3,800 person / $6,000 family Tier 2<br>$4,500 person / $7,400 family Tier 3 | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | $1,900 person / $3,800 family Tier 1<br>$5,500 person / $10,000 family Tier 2<br>$6,700 person / $12,400 family Tier 3 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| **What is not included in the out–of–pocket limit?** | Penalties, premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits |
| | Specialist visit | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | No charge; Deductible Waived | No charge; Deductible Waived physician all ages; 30% Coinsurance; Deductible Waived facility to age 18; 30% Coinsurance facility from age 18 | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% Coinsurance | 10% Coinsurance office setting; 20% Coinsurance outpatient setting | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits office setting |
| | Imaging (CT/PET scans, MRIs) | 10% Coinsurance | 10% Coinsurance office setting; 20% Coinsurance outpatient setting | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits office setting |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at https://app.cap-rx.com/login. | Generic drugs (Tier 1)<br>- after deductible | After calendar year deductible is met 10% Co-insurance will apply | After calendar year deductible is met 20% Co-insurance will apply | After calendar year deductible is met 20% Co-insurance will apply | Prescription Drugs. The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs (Tier 3), as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. Prescription drugs considered non-formulary are not covered. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office or call Capital Rx Customer Care at 1-888-302-2779. |
| | Preferred brand drugs (Tier 2) - after deductible | | | | |
| | Non-preferred brand drugs (Tier 3) - after deductible | | | | |
| | Specialty drugs (Tier 4)<br>- after deductible | | | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | None |
| | Physician/surgeon fees | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon |
| **If you need immediate medical attention** | Emergency room care | 10% Coinsurance | 10% Coinsurance | 10% Coinsurance | Tier 1 deductible applies to Tier 2 & 3 benefits |
| | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | 10% Coinsurance | Tier 1 deductible applies to Tier 2 & 3 benefits |
| | Urgent care | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician/surgeon; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Physician/surgeon fees | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits |
| | Inpatient services | 10% Coinsurance | 20% Coinsurance facility; 10% Coinsurance physician | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | No charge; Deductible Waived | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits physician; Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | |
| | Childbirth/delivery facility services | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 | |
| **If you need help recovering or have other special health needs** | Home health care | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | 90 Maximum visits in a 12 month period; Preauthorization is required. |
| | Rehabilitation services | 10% Coinsurance | 10% Coinsurance office therapy; 20% Coinsurance hospital therapy | 30% Coinsurance | Tier 1 deductible applies to Tier 2 benefits office therapy; 60 Maximum visits per calendar year |
| | Habilitation services | 10% Coinsurance | 10% Coinsurance office therapy; 20% Coinsurance hospital therapy | 30% Coinsurance | |
| | Skilled nursing care | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 20% Coinsurance | 30% Coinsurance | Tier 2 deductible applies to Tier 1 benefits; Preauthorization is required for DME in excess of $500 for rentals or purchases. |
| | Hospice service | 10% Coinsurance | 20% Coinsurance | 30% Coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | 10% Coinsurance | 10% Coinsurance | 30% Coinsurance | 1 Maximum exam per calendar year |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery | • Private-duty nursing (Outpatient care) | • Routine eye care (Adult) |
| • Chiropractic care | | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**Does this plan Provide Minimum Essential Coverage? Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan Meet the Minimum Value Standard? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,700 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,700 |
| Copayments | $0 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,960** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,700 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,700 |
| Copayments | $0 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,920** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,700 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,700 |
| Copayments | $0 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $00 |
| **The total Mia would pay is** | **$1,800** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.