OUR BENEFITS ARE SWEET!

Employee Benefit Summary

January 1, 2023

Visit: https://member.maxwellhealth.com/login to elect your benefits.

Spencer Hospital

DISCLAIMER

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by your company.

If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.

The information in this booklet is proprietary. Please do not copy or distribute to others.

Contained within this document is your annual Medicare Part D notice as required by the Centers for Medicare & Medicaid. Please see the table of contents for page number.

Created by Holmes Murphy & Associates for Spencer Hospital.

HOLMES MURPHY.

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HOLMES MURPHY.

CUSTOMER SERVICE CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL:
HealthPartners
(800) 883-2177
www.healthpartners.com

DENTAL:
Delta Dental of Iowa
(800) 544-0718
www.deltadentalia.com

VISION:
MetLife
(855) 638-3931
www.metlife.com

FLEXIBLE SPENDING ACCOUNTS (FSA):
WEX
(866) 451- 3399
www.wexinc.com

LIFE/AD&D/DISABILITY:
SunLife
(800) 862-6266
www.sunlife.com

VOLUNTARY SUPPLEMENTAL:
SunLife
(800) 247-6875
www.sunlife.com

EMPLOYEE ASSISTANCE PROGRAM:
EFR Employee & Family Resources
(800) 327-4692
www.efr.org/myeap

RETIREMENT:
IPERS
(800) 622-3848
(515) 281-0053
www.ipers.org

ADDITIONAL RETIREMENT:
IA Retirement Investors' Club
(515) 242-5120
www.ric.iowa.gov

ONLINE ENROLLMENT PLATFORM:
Maxwell Health
(866) 629-7445
www.maxwellhealth.com

HUMAN RESOURCES CONTACTS:

Beth Henningsen	HR Generalist	(712) 264-8451	bhenningsen@spencerhospital.org
Candace Daniels	HR Generalist	(712) 264-6643	cdaniels@spencerhospital.org
Jennifer Engel	HR Generalist	(712) 264-6125	jengel@spencerhospital.org
Michael Schauer	HR Director	(712) 264-6642	mschauer@spencerhospital.org
Tatum Geerdes	Employee Health	(712) 264-6636	tatum.geerdes@spencerhospital.org
Stacy Yarkosky	HR Assistant	(712) 264-6205	stacy.yarkosky@spencerhospital.org

KEY HIGHLIGHTS FOR 2023

What's New?

- Health Savings Account Limits
  - $3,850
  - $7,750
- Flexible Spending Limits
  - $3,050 Medical care maximum
  - $3,050 Limited purpose maximum
  - $5,000 Dependent care maximum

What's Changing?

- Medical – plan design changes and lower premium on Traditional plan! No plan changes and slight increase to premiums on HSA plan.
- HSA – employer-sponsored option to make your own pre-tax contributions!
- Voluntary Accident/Critical Illness/Hospital Indemnity – moving to SunLife with lower rates!
- Life & Disability – new carrier, SunLife, but no plan changes
  - **Please note:** your voluntary life rate could change should you age into a new age bracket at the beginning of the plan year
- Additional EAP option through ComPsych – both EFR and ComPsych's Employee Assistance Programs are available at no cost to you.

What's Remaining the Same?

- Dental – no changes
- Vision – no changes

WHO IS ELIGIBLE?

If you are a full-time employee (working 60-72 hours per pay period), part-time employee (working 40-59 hours per pay period) or weekend package with benefits you are eligible to enroll in the benefits described in this guide. In accordance with Health Care Reform legislation, Spencer Hospital does have a one-year measurement period for hours of service and a one-year stability period, upon completion of one year of employment, so a PRN, CPT, or PT might qualify for FT benefits. You and your family members are eligible for medical, dental, vision, life-disability and optional supplemental products through Spencer Hospital.

New Hire effective dates by benefit

Medical-1st of the month following one full month of employment
Providers eligible 1st of the month following date of hire
Wellness-New employees are grandfathered into wellness until the following years screenings
Dental-1st of the month following one full month of employment
Vision-1st of the month following one full month of employment
Flexible Spending-1st of the month following one full month of employment
Life & AD&D- 1st of the month following 90 days of employment
Short-Term Disability-After one full year of employment
Long-Term Disability-1st of the month following 90 days of employment
EAP-Upon hire
IPERS-Upon hire, except PRN must work two consecutive quarters making $1,000 or more.
Deferred Compensation-Upon hire

HOW TO ENROLL

Simply login to www.maxwellhealth.com to review your current benefit and make any election changes for 2023. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

WHEN TO ENROLL

The open enrollment period runs from October 24th through November 11th. The benefits you elect during open enrollment will be effective from January 1, 2023 through December 31, 2023.

WHEN TO MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status, reduction in hours, or marketplace open enrollment. See HIPAA Special Enrollment Rights later in this packet for notification requirements.

If you are adding your spouse and/or children to Spencer Hospital's health, dental or vision insurance, we will need the following documents provided prior to start of coverage. Coverage will not start until documentation has been provided.

Relationship(s)	Required Documentation
Legal Spouse	**Standard Document**: Marriage certificate (recognized legal jurisdiction) + (1) Joint Document **In addition to your marriage certificate, you will be required to provide joint documentation.** Joint documentation is an item addressed to both parties and dated within the last 90 days. **Examples of Acceptable Joint Documentation**: Utility Bill, Mortgage Statement, Auto Insurance Statement, Property Tax Statement or your 2016 or 2017 Federal Income Tax Form – 1040
Biological/adopted child	**Standard Document**: Birth certificate or court document (paternity test or divorce decree)
Stepchild	**Standard Document**: Birth certificate or court document (paternity test or divorce decree) & confirm eligibility of the spouse
Child placed for adoption	**Standard Document**: document establishing the child has been placed for the purpose of adoption
Legal Guardianship	**Standard Document**: Court document assigning minor child to employee under permanent legal guardianship.
Dependents over age 26	**Standard Document**: Birth certificate or court document **Question**: Is this dependent married? If yes, please provide the date of marriage. Is this dependent enrolled as a full-time student at an accredited institution of higher education? If yes, please provide proof of their enrollment.

If you do not have a required certificate or document copy, please order it immediately. The vital statistics website (http://www.cdc.gov/nchs/w2w.htm) can help you determine the process for obtaining document copies. You may be required to contact the County Clerk's office directly and there may be non-reimbursable costs associated with obtaining new copies.

Maxwell | Health™

All your company benefits, anywhere you go!

Manage and shop for all the same great benefits information you see online in Maxwell, straight from your phone. Log in to our secure app wherever and whenever you want.

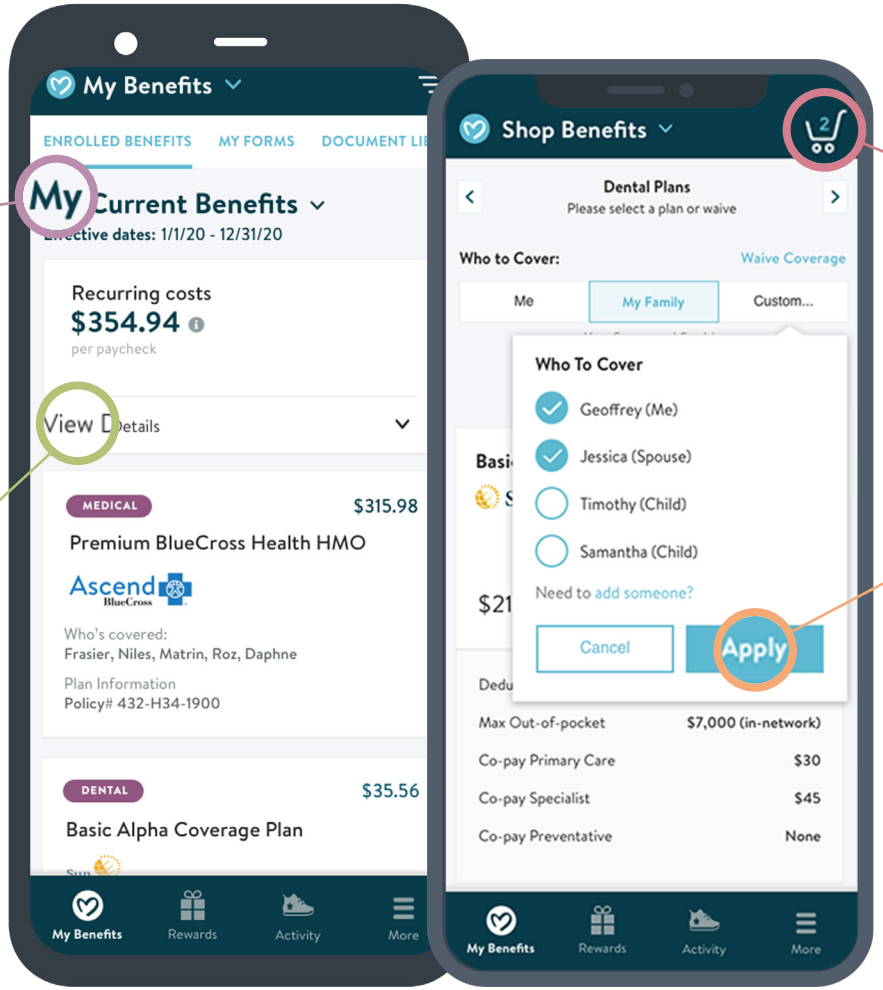
With the Maxwell mobile app you can:

VIEW YOUR BENEFITS ON-THE-GO

Continue to access coverage details for all of your benefits on Maxwell

GET A FULL FINANCIAL VIEW OF YOUR BENEFITS

With all the benefit details included in the app, you can continue to keep a pulse on benefit costs from wherever you are



SHOP FOR YOUR BENEFITS

When it's time for enrollment, you can choose and enroll in benefits quickly and simply right from the mobile app.

MAKE CHANGES TO YOUR BENEFITS

Use the app to make important updates to benefits when life events happen, like getting married or having a baby

Download the app for Android and Apple devices

GET IT ON Google Play

Download on the App Store

MEDICAL INSURANCE

Health Partners

Traditional PPO Plan-This is a PPO plan with two in-network tiers. If you use a Tier 1 provider, you will receive greater benefits. To locate an in-network provider visit www.healthpartners.com/openaccess or call (866) 843-3461. Please see the next page for a list of Tier 1 providers.

Plan Feature	Tier 1	Tier 2	Out-of-Network(1)
Deductible (Calendar Year)	$1,000 single $2,000 family* *(single deductible per person)*	$2,000 single $4,000 family* *(single deductible per person)*	$4,000 single $8,000 family* *(single deductible per person)*
Coinsurance	20%		40%
Medical Out-of-Pocket Maximum (Calendar Year)	$3,500 single $7,000 family		$6,000 single $12,000 family
Prescription Out-of-Pocket Maximum (Calendar Year)	$3,600 single $7,200 family		$3,600 single $7,200 family
Office Visit Copayment	$25 PCP Copayment $40 Specialist Copayment *Other charges may be subject to deductible*		Deductible, 40% coinsurance
ER Provider Copayment	$100 (waived if admitted)		
Retail Prescription Drug Coverage (30 day supply)	Tier 1: 10% with a minimum $5 copay, maximum $15 Tier 2: 10% with a minimum $30 copay, maximum $60 Tier 3: 10% with a minimum $50 copay, maximum $100 Specialty: 10% with a minimum $125 copay, maximum $250		Deductible, 40%
Retail Prescription Drug Coverage (90 day supply)	Tier 1: 10% with a minimum $10 copay, maximum $30 Tier 2: 10% with a minimum $60 copay, maximum $120 Tier 3: 10% with a minimum $100 copay, maximum $200		Not Covered

EMPLOYEE COST	Full-Time per Pay Period	Part-Time per Pay Period
Employee	$75.00	$182.00
Employee/Spouse	$280.00	$400.00
Employee/Child(ren)	$230.00	$333.00
Family	$290.00	$405.00

(1) For out-of-network providers, the member may incur some charges above usual, customary and reasonable, which are the responsibility of the member and do not apply to the out-of-pocket maximum.

(2) In and out-of-network deductibles and out-of-pocket maximums do apply to each other.

(3) Premiums are paid on a pre-tax basis by payroll deduction 24 of the 26 annual pay periods. These are the base rates; wellness rates may apply. See Wellness Criteria flow chart for more information.

Tier 1 Providers

Location Name	City
Abben Cancer Center of Spencer Hospital	Spencer
Avera Medical Group Spencer a Department of Spencer Hospital	Spencer
Hartley Family Care	Hartley
Iowa Spine Care	Pocahontas
Iowa Spine Care	Sibley
Iowa Spine Care	Spencer
Iowa Spine Care	Spirit Lake
Iowa Spine Care	Storm Lake
Milford Family Care	Milford
Northwest Iowa Anesthesia Associates	Emmetsburg
Northwest Iowa Anesthesia Associates	Pocahontas
Northwest Iowa Anesthesia Associates	Spencer
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Cherokee
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Emmetsburg
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Estherville
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Pocahontas
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Primghar
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Sheldon
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Sibley
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Spencer
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Spirit Lake
Northwest Iowa Bone, Joint & Sports Surgeons, PC	Storm Lake
Northwest Iowa Ear Nose & Throat, PC	Cherokee
Northwest Iowa Ear Nose & Throat, PC	Spencer
Northwest Iowa Ear, Nose & Throat	Estherville
Northwest Iowa Surgeons, PC	Emmetsburg
Northwest Iowa Surgeons, PC	Estherville
Northwest Iowa Surgeons, PC	Pocahontas
Northwest Iowa Surgeons, PC	Spencer
Northwest Iowa Surgeons, PC	Spirit Lake
Northwest Iowa Urologists, PC	Spencer
Physician's Laboratory Ltd	Sioux Falls
Physicians Laboratory of Northwest Iowa, Ltd	Spencer
Rehab @ the Clinic	Spencer
Sioux Rapids Family Care	Sioux Rapids
Spencer Hospital - Spirit Lake Dialysis	Spirit Lake
Spencer Municipal Hospital	Spencer
Warner Dialysis Center	Spencer

MEDICAL INSURANCE

Health Partners

HDHP-Health Savings Account-This is a HDHP plan. If you use in-network providers, you will receive greater benefits. To locate a preferred provider visit www.healthpartners.com/openaccess or call (866) 843-3461.

Plan Feature	In-Network	Out-of-Network(1)
Deductible (Calendar Year)	$2,500 single $5,000 family* *(any combination of one or more family members)*	$5,000 single $10,000 family* *(any combination of one or more family members)*
Coinsurance	0%	40%
Out-of-Pocket Maximum (Calendar Year)	$2,500 single $5,000 family	$5,000 single $10,000 family
Office Visit Copayment	Deductible, 0% coinsurance	Deductible, 40% coinsurance
ER Provider Copayment	Deductible, 0% coinsurance	
Retail Prescription Drug Coverage (30 day supply)	Deductible, 0% coinsurance	Not Covered
Retail Prescription Drug Coverage (90 day supply)	Deductible, 0% coinsurance	Not Covered

EMPLOYEE COST	Full-Time per Pay Period	Part-Time per Pay Period
Employee	$40.00	$104.00
Employee/Spouse	$137.00	$227.00
Employee/Child(ren)	$115.00	$190.00
Family	$161.00	$247.00

(1) For out-of-network providers, the member may incur some charges above usual, customary and reasonable, which are the responsibility of the member and do not apply to the out-of-pocket maximum.
(2) In and out-of-network deductibles and out-of-pocket maximums do apply to each other.
(3) Premiums are paid on a pre-tax basis by payroll deduction 24 of the 26 annual pay periods. These are the base rates; wellness penalties may apply. See Wellness Criteria flow chart for more information.

* This plan costs $840 per year less in premiums for single than the Traditional and $3,096 less per year for a Full-Time family.

MEDICAL INSURANCE PLAN LANGUAGE UPDATES

Health Partners

Below are plan language updates that are effective January 1, 2023.

Benefit	Current Plan Language	Plan Language effective January 1, 2023
Out-of-Network Urgent care	Covered at out-of-network level	Covered at in-network level
Male Sterilization Procedure	Covered at 100%	Covered at outpatient surgery level
Infertility Treatment	Include coverage for Assisted Reproductive Technology (ART) procedures such as IVF, GIFT, ZIFT	Only artificial insemination and intrauterine insemination covered*
Physical Therapy / Occupational Therapy / Speech Therapy	Covered based on place of service: in-office=copay, outpatient=deductible, coinsurance	Copay applies for services received in office or outpatient setting (impacts traditional plan only)
Dental Orthognathic Surgery (jaw)	Excluded	Covered
Treatment of Temporomandibular Disorder (TMJ)	Excluded	Covered
Wigs for hair loss resulting from alopecia and/or chemotherapy	Excluded	Covered
Transplant Travel Benefit	Excluded	Covered up to $10,000

**If you are already in-process with ART procedures or have something scheduled for early 2023, please contact Candace Daniels.*

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, call 1-866-843-3461 or visit us at www.healthpartners.com. 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.healthcare.gov/sbc-glossary or call 1-866-843-3461 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Level 1: $1,000 Individual, $2,000 Family Level 2: $2,000 Individual, $4,000 Family Out-of-network: $4,000 Individual, $8,000 Family	Generally, you must pay all of 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. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network medical: $3,500 Individual, $7,000 Family Out-of-network medical: $6,000 Individual, $12,000 Family Pharmacy: $3,600 Individual, $7,200 Family	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?	Pharmacy copays, pharmacy coinsurance, premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks or call 1-866-843-3461 for a list of in-network providers.	This plan uses a provider network. You pay the least if you use a provider in Level 1. You pay more if you use a provider in Level 2. 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: $25 copay* Convenience Care: $15 copay* virtuwell: $15 copay*	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance virtuwell: Not covered	None
	Specialist visit	$40 copay*	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	10% coinsurance*	40% coinsurance at retail, mail not covered	30 day supply retail / 90 day supply mail order Formulary Generic: $5 min/$15 max copay; Non-Formulary Generic: $50 min/$100 max copay; Formulary Brand: $30 min/$60 max copay; Non-Formulary Brand: $50 min/$100 max copay
	Formulary brand drugs	10% coinsurance*		
	Non-formulary brand drugs	10% coinsurance*		
	Specialty drugs	10% coinsurance*	40% coinsurance at retail, mail not covered	$250 maximum copay per prescription per month

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$40 copay*	$40 copay*	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$25 copay*	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$25 copay*	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$25 copay*	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day maximum
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	20% coinsurance	40% coinsurance	Respite care is limited to 5 episodes, up to 5 days per episode; Inpatient hospice services are limited to 15 days per lifetime
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	
• Acupuncture		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility treatment	• Routine eye care (Adult)
	• Non-emergency care when traveling outside the U.S.	

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: Your plan at:1-866-843-3461 or the 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. For more information about your rights, this notice, or assistance, contact:Your plan at: 1-866-843-3461.

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 Minimum Value Standards? 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 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-843-3461.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-843-3461.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-843-3461.

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	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal 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	$1,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$900
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$900
The total Mia would pay is	**$2,080**

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, call 1-866-843-3461 or visit us at www.healthpartners.com. 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.healthcare.gov/sbc-glossary or call 1-866-843-3461 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,500 Individual, $5,000 Family contract Out-of-network: $5,000 Individual, $10,000 Family contract	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network: $2,500 Individual, $5,000 Family contract Out-of-network: $5,000 Individual, $10,000 Family contract	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?	Premium, balance-billed charges (unless balanced billing is prohibited), 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 https://www.healthpartners.com/networks or call 1-866-843-3461 for a list of in-network providers.	This plan uses a provider network. You pay the least if you use a provider in Level 1. You pay more if you use a provider in Level 2. 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance virtuwell: Not covered	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	0% coinsurance	40% coinsurance at retail, mail not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	0% coinsurance	40% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

10

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance for Level 1/20% coinsurance for Level 2	40% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	40% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	40% coinsurance	Respite care is limited to 5 episodes, up to 5 days per episode; Inpatient hospice services are limited to 15 days per lifetime
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine foot care
• Cosmetic surgery	• 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.)		
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Infertility treatment		

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: Your plan at:1-866-843-3461 or the 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. For more information about your rights, this notice, or assistance, contact:Your plan at: 1-866-843-3461.

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 Minimum Value Standards? 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 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-843-3461.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-843-3461.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-843-3461.

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	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal 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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,500**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

You're covered from coast to coast

We're so happy to have you as a HealthPartners member

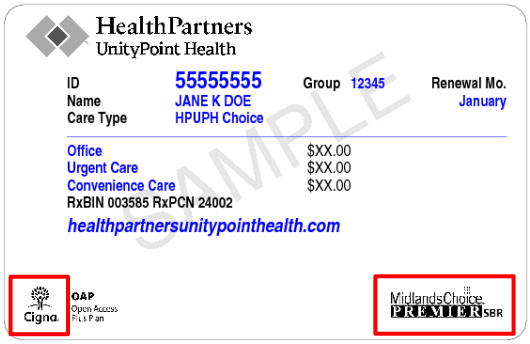
Your health insurance is from HealthPartners, and we partner with Midlands Choice and Cigna. That means you have a lot of doctors and clinics in your network.

Here are some ways to find a doctor:

- Go to **healthpartners.com/openaccess** or download the **myHP** mobile app. Select "Find Care" to search by ZIP code, specialty or location.
- Give your Member Services team a call at **866-843-3461.**

How will your doctor know you're covered?

Show the office staff your member ID card. Point to the Midlands Choice and Cigna logos on the front of the card. If your doctor's office has questions, show them the back of your card for contact information.



P.S. Don't forget!

You can always find your member ID card on the **myHP** app. You can fax a copy to your doctor's office.

Remember, we're here to help.

Call us with any questions at **866-843-3461**. We're here to help you understand your coverage, claims, benefits and more.

HealthPartners®

HealthPartners
UnityPoint Health

Get the most from your meds

Knowing what you'll pay for your medicine is important. Use these tools and resources to understand your costs and get support if your medicine isn't working for you.

Check your formulary

A formulary, also called a drug list, tells you what medicines are covered by your health plan and generally how much you'll pay. You'll also learn if there are any requirements before you can start a medicine.

Your formulary is called PreferredRx.

1. Go to **healthpartners.com/preferredrx**
2. Search by the name or type of medicine.
3. Use your Summary of Benefits and Coverage (SBC) in your enrollment materials to understand how each type of medicine is covered.

Try generics

Generics are just as safe and effective as brand-name medicines, but cost a lot less. Talk to your doctor or pharmacist about switching to a generic medicine.

Search for the lowest cost

Medicine prices can change from pharmacy to pharmacy. Shop around. See what your costs are at different pharmacies. Members can get started with the prescription shopping tool at **healthpartners.com/pharmacy**

Talk with a Pharmacy Navigator

One call will give you answers to your questions around benefits, coverage, costs, formularies and more. Call Member Services at the number on the back of your member ID card. Ask to talk with a Pharmacy Navigator.

Meet with a pharmacist

In a one-on-one visit, a pharmacist will review your medicines with you to make sure they're working and are right for you. Plus, it's free. Visit **healthpartners.com/mtminfo** to learn more.

Questions about benefits?

We can help. Call Member Services at **866-843-3461**

Our team is here to support you. If you can't find your medicine on the formulary or shopping tool, give us a call. We'll help you find it or an alternative that's covered.
Kerry, Pharmacy Navigator

HealthPartners®

Care today for a healthy tomorrow

Prevent problems before they start so you can enjoy the things you love. Your health plan covers in-network preventive care at 100%; you don't pay anything.

Protect your health with routine visits

Even if you're not sick, it's smart to go in for regular checkups and screenings. If there are any issues, you can catch them early – when treatment is most effective.

Preventive care includes:

- Alcohol, tobacco and weight screenings
- Blood pressure, diabetes and cholesterol tests
- Colorectal, breast and cervical cancer screenings
- Routine pre- and post-natal care
- Vaccines
- Well-child visits
- And more!

Visit **healthpartners.com/preventive** to find out what care is recommended for you.

Questions about benefits?

We can help. Call Member Services at **866-843-3461.**

I always encourage members to go in for their screenings. If you're ever wondering whether a service counts as routine preventive care, give us a call.
Renae, Member Services

HealthPartners

Live your best life

We can help you get healthy and live better, no matter what your goals are. These programs and resources are free for HealthPartners members.

If you want to	You can	Here's how
Quit smoking	Talk with a health coach	Call **800-311-1052**
Eat better	Find tasty recipes	Visit **powerup4kids.org**
Manage your weight	Talk with a health coach if you're an adult with a body mass index of 30 or greater	Call **952-883-7800**
Save money	Get discounts on exercise equipment, eyeglasses and more	Visit **healthpartners.com/discounts**
Meet other people like you	Sign up for a class or group session for things like asthma, car seat clinics, weight loss and more	Visit **healthpartners.com/classes**
Get your health questions answered	Talk with a nurse 24/7	Call **800-551-0859**
	Search health topics or use a symptom checker	Visit **healthpartners.com/healthlibrary**
Make sure you're getting the right care	Talk with a nurse to figure out what care is best for you	Call Member Services at the number on the back of your member ID card. Ask for a nurse navigator.
Make sure your medicine is working the way it should	Talk with a pharmacist	Visit **healthpartners.com/mtminfo**

You're busy and it's hard to find time to do the healthy stuff you want. We get it. We can help.

Sara, Health Coach

Enjoy the life you want

Find even more support at **healthpartners.com/livingwell** or go to *Living Well* on the myHP app.

HealthPartners
UnityPoint Health

Here for you, 24/7

Call us at one of these numbers if you have questions about your health or what your plan covers. We're ready to help.

Member Services		
For questions about: • Your coverage, claims or plan balances • Finding a doctor, dentist or specialist in your network • Finding care when you're away from home • Health plan services, programs and discounts		Monday – Friday, 7 a.m. to 6 p.m. CT Call the number on the back of your member ID card, **866-843-3461**. Interpreters are available if you need one. Español: **866-398-9119** **healthpartnersunitypointhealth.com**
Member Services can help you reach:		
Nurse Navigator℠ program	**For questions about:** • Understanding your health care and benefits • How to choose a treatment	Monday – Friday, 7:30 a.m. to 5 p.m. CT
Pharmacy Navigators	**For questions about:** • Your medicines or how much they cost • Doctor approvals to take a medicine (prior authorization) • Your pharmacy benefits • Transferring medicine to a mail order pharmacy	Monday – Friday, 8 a.m. to 5 p.m. CT
Behavioral Health Navigators		
For questions about: • Finding a mental or chemical health care professional in your network • Your behavioral health benefits		Monday – Friday, 8 a.m. to 5 p.m. CT **888-638-8787**
CareLine℠ service nurse line		
For questions about: • Whether you should see a doctor • Home remedies • A medicine you're taking		24/7, 365 days a year **800-551-0859**
BabyLine phone service		
For questions about: • Your pregnancy • The contractions you're having • Your new baby		24/7, 365 days a year **800-845-9297**

One thing I love about my job is how my team helps people all day, every day.
Rachel, Registered Nurse, CareLine

Plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc., a subsidiary of HealthPartners, Inc.

HealthPartners
UnityPoint Health

Take charge of your health plan

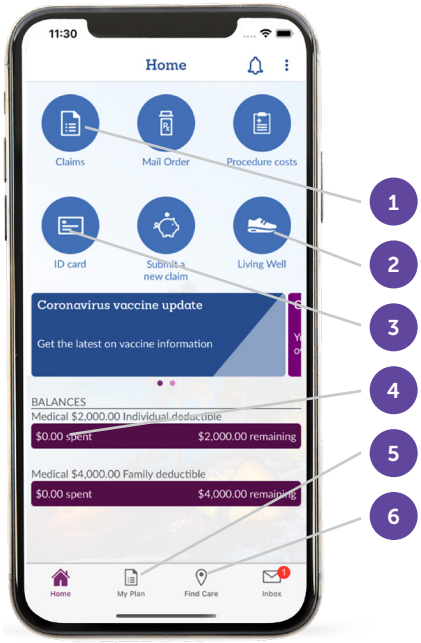
You go online to research, plan and follow up on big decisions. A HealthPartners online account makes it just as easy to stay on top of your health care and insurance.

Get personalized information when and where you need it

With an online account, you have real-time access to your personal health plan information in one simple place. No more guessing or waiting until business hours to get answers to your questions.

Top 6 ways to use your online account and mobile app

1. See recent claims, what your plan covered and how much you could owe.
2. Access your Living Well dashboard to check your program progress, take the health assessment and complete activities.
3. View your HealthPartners member ID card and fax it to your doctor's office.
4. Check your balances, including how much you owe before your plan starts paying (deductible) and the most you'll have to pay (out-of-pocket maximum).
5. Compare pharmacy costs to find the best place to get your medicines.
6. Search for doctors specific to your plan.



Sign in to your account

Manage your health and your plan at **healthpartnersunitypointhealth.com** or the **myHP** app.

Don't have an account yet? It's quick and easy to sign up – you'll just need your member ID card.

I love directing members to their online accounts and the mobile app. You can easily get your health plan info, even when I'm not in the office.
Jarria, Member Services

Plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc., a subsidiary of HealthPartners, Inc.

HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATION

HSA Overview

NEW this year, you have the option to make pre-tax contributions to your HSA through WEX. You may keep your current HSA and open a new account with WEX, although you are not required to.

HSA Account Trustee: WEX

Debit card: included

HSA Investment options: included with a minimum balance of $1,000

Account Provisions

Who is eligible?

1) Anyone covered under a qualified High Deductible Health Plan (HDHP) on the first day of the month, but not covered under any other medical plan.
2) Anyone not enrolled in Medicare. **Note**: an actively at-work employee who is older than 65 may not enroll in an HSA unless he/she has waived Medicare.

> For individuals who delay enrolling in Medicare, Part A coverage may retroactively begin six months prior to their application date. To avoid making excess HSA contributions (and incurring a tax penalty), CMS recommends that individuals stop contributing to their HSAs at least six months before applying for Medicare.

3) When contributing to an HSA, member and spouse (if applicable) may only participate in a "limited-purpose" flexible spending account.
4) Anyone not claimed as a dependent on another person's tax return.

Is there a limit on the amount that can be contributed per year?

$3,850 for an individual plan, $7,750 for a family plan for 2023. These numbers are indexed annually by the Treasury Department. In addition, individuals age 55 or older are allowed a $1,000 catch-up contribution.

What are the advantages of enrolling in an HSA?

1) Monies go in tax-free.
2) Monies grow tax-free.
3) Monies come out tax-free if spent on qualified medical expenses.
4) Unspent monies roll over year to year, grow, and earn interest.
5) The account owner decides whether to use the HSA dollars for current expenses or to save them for future expenses.
6) The account is portable.

What expenses are eligible for reimbursement?

Internal Revenue Code Section 213(d) medical expenses for the employee and qualified dependents (even if the dependents are not on the employee's HDHP); COBRA premiums; qualified long-term care expenses; retiree medical premiums to employer-sponsored medical coverage (if age 65 or older); Medicare Parts B & D premiums, but not Medicare supplement premiums.

What if funds are used for non-qualified expenses?

Distributions for an account owner under age 65 are subject to income tax plus a 20% penalty. Distributions for an account owner 65 and older are subject to income tax only.

For more details:

Check out www.irs.gov for more details.

Health Savings Account

Why should I choose a health savings account (HSA)?

An HSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool. This plan offers tax savings that a 401(k) and IRA don't, making it a powerful option for diversifying your retirement portfolio.

It's yours
Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Flexibility
Save for a rainy day. Invest for your future retirement. Or spend your funds on qualified expenses, penalty free.

Easy to use
Swipe your benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings
The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

Investment options
You can invest your HSA funds in an interest-bearing account or our standard mutual fund lineup. Savvy investors may opt for a Health Savings Brokerage Account powered by Charles Schwab, giving you access to more than 8,500 mutual funds, stocks and bonds.

What does it cover?

There are thousands of eligible items. The list includes but is not limited to:

- Copays, coinsurance, insurance premiums
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

View our searchable list of eligible expenses at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

Can I enroll?

You must be enrolled in a high-deductible health plan (HDHP) in order to enroll in the HSA. You're not eligible for an HSA if:

- You're claimed as a dependent on someone else's taxes.
- You're covered by another plan that conflicts with the HDHP, such as Medicare, a medical flexible spending account (FSA) or select health reimbursement arrangements (HRAs).
- You or your spouse are contributing to a medical FSA.

UNDERSTANDING YOUR BENEFITS

Medical Plan Terms

What is a PPO?
PPO stands for Preferred Provider Organization. It is a network of doctors, hospitals, and other healthcare providers that participate in a managed care plan. Members receive greater benefits by staying within the network but also have the option of receiving medical care outside of the network.

In choosing the PPO option, you and the covered members of your family may select care in or out-of-network. No primary care physician (PCP) is required and you may see a specialist without a referral from your regular doctor. In-network care provides the highest level of benefits and lower out-of-pocket expenses. In choosing a healthcare provider outside of the network, you will incur higher out-of-pocket expenses, which could include charges above usual, customary, and reasonable.

What is an HMO?
HMO stands for Health Maintenance Organization. It is a network of doctors, hospitals, and other healthcare providers that participate in a more tightly managed care plan. Members receive benefits by staying within the network; there are no benefits when using non-preferred providers unless the services are for a life or limb threatening emergency.

What is a Qualified High Deductible Health Plan (QHDHP) and what is a Health Savings Account (HSA)?
A QHDHP protects you from catastrophic medical bills. This plan contains a deductible which must be met before the health plan provides coverage – this typically means that 100% of the charges you and your family members incur for health and prescription services are subject to the deductible – this plan has no copays for office visits, prescription, etc. The federal government has set various guidelines on the qualified deductible amounts, the rules on making withdrawals, etc. Please review all your medical plan information carefully, before enrolling in this plan.

Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (I.R.C. Sec. 223) was effective 1/1/2004. This law created a tax-advantaged trust or custodial account for the benefit of an individual covered under a QHDHP. Your Health Savings Account (HSA) is your own tax-exempt trust account that you can use to pay for your current medical expenses, including out-of-pocket expenses, coinsurance, and deductibles. Or, you may elect to save these HSA dollars for future unreimbursed expenses. *The choice is yours!*

How does an HSA work?
An HSA allows you to make tax-free payroll contributions to an account that you may then use to pay for certain out-of-pocket medical expenses. Paying for certain expenses with tax-free dollars reduces the amount you pay in taxes and increases your take-home pay. To be eligible to open an HSA, you must participate in a Qualified High Deductible Health Plan. Your employer may also make deposits into your HSA, on your behalf. If this is your case, then you will need to subtract the employer HSA contribution from the annual maximum contribution amount, to determine what you may contribute through payroll deduction. Example: you are enrolling as a single in a HDHP, and your employer is contributing $500. You would subtract $500 from the annual maximum contribution of $3,850 to determine that you may contribute up to $3,350 of your own dollars.

Funds in your Health Savings Account accumulate on a tax-free basis, and if the funds are used for *qualified* medical expenses, they are never taxed. This includes most medical care and services, dental and vision care, and also includes over-the-counter drugs. If you do withdraw HSA monies for *a non-qualified* expense, however, you would be subject to a 20% excise penalty, and you would be required to pay income taxes on the amount withdrawn. Please note that after you turn age 65, the 20% additional penalty no longer applies.

HSA monies may be used to pay for certain medical insurance premiums. Under today's tax laws, qualified premiums include: COBRA, qualified long-term care insurance, Medicare premiums and out-of-pocket expenses including deductibles, copays, and coinsurance for Part A (hospital and inpatient services), Part B (physician and outpatient services), Part C (Medicare HMO and PPO plans), and Part D (prescription drugs).

You can use the money in the account to pay for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP.

NOTE: For those employees who enroll into a Qualified High Deductible Health Plan/Health Savings Account, you may only participate in the Health Care Flexible Spending Account on a *limited* basis: i.e., you may only defer expenses for dental and vision expenses, not medical services that are subject to the high deductible in the QHDHP.

Who is eligible to participate in a Health Savings Account?

There are several rules to follow that include, but are not limited to:

1. You must be covered under a qualified high deductible health plan, that has the following features:
    a. Minimum deductible of $1,500 for single coverage; $3,000 for family coverage
    b. Maximum out-of-pocket of $7,500 for single coverage; $15,000 for family coverage
2. You may not be covered under any first-dollar medical plan (note: other types of insurance like specific injury insurance or accident, disability, dental, vision, or long-term care insurance are permitted)
3. You may not be enrolled in Medicare
4. You may not be claimed as a dependent on someone else's tax return

What is the maximum contribution that can be made to an HSA?

In 2023, $3,850 for self-only coverage, and $7,750 for family coverage. These amounts are adjusted annually for inflation.

In addition, individuals who are age 55 or older can also make "catch-up" contributions. The maximum annual catch-up contribution is as follows:

2013 and beyond – $1,000

What are the advantages of enrolling in a HDHP/HSA?

There are a number of advantages:

- Security – your high deductible health plan protects you in the case of catastrophic accident or illness.
- Affordability – the premiums for HDHP's are typically lower than a 'traditional' health plan.
- Flexibility – you may use the funds in your HSA to pay for current or future medical expenses.
- Savings – you can save the money in your HSA and have it grow on a tax-deferred basis.
- Control – you decide how to spend the money in your account, and you decide how to invest the monies as well.
- Portability – your HSA account is completely portable and goes with you if you would leave your current employer, become unemployed, change your medical coverage, move to another state, or change your marital status.
- Ownership – you own the funds in your HSA account, even the dollars your employer may contribute on your behalf. There are no "use it or lose it" rules for HSA's.
- Tax Savings – there are three ways your HSA account provides tax savings:
    - Your contributions go in tax-free
    - The monies earn interest on a tax-deferred basis
    - Withdrawals are tax-free for qualified medical expenses

WELLNESS

Our wellness benefits are constantly evolving. We strive to slow the progression of disease. Typically, our annual wellness screenings take place in January for both employees and spouses on our health plan. More information on how to register will be announced.

NEW HIRES: If you are hired after the main screenings, we typically grandfather employees in until the next year. However, if you would like to know your numbers prior to the main screening, please contact Employee Health RN, Tatum Geerdes at 264-6636 to set a personalized time.

Note: If it is unreasonably difficult due to a medical condition for you to achieve the criteria under this program, or if it is medically inadvisable for you to attempt to achieve the criteria under this program, call Employee Health at 6636 and we will work with you to develop another way to qualify for the program.

Know Your Wellness Benefits

2023 Spencer Hospital Wellness Benefits

Spencer Hospital
Healthier Together.

ELIGIBILITY	YOUR COST	DESCRIPTION
Comprehensive Wellness Screening including Preventive Blood Work		*Contact Employee Health at 264-6636*
Employees on Health Plan *January*	FREE *Value:$50/each* *$10/Thyroid* *$25/PSA*	Includes: Height, Weight, & Waist Circumference, Resting Blood Pressure & Heart Rate, Complete Blood Count (CBC), Lipid Panel (HDL, LDL, Triglycerides & Cholesterol), Comprehensive Chemistry Panel, Prostate Specific Antigen (PSA) - Optional by request- Males over 50, Thyroid (TSH) - All age 35+.
Employees NOT on Health Plan & Spouses	$10 *(See value above)*	
Naturally Slim		*Contact Employee Health at 264-6636*
Employees & Spouses on Health Insurance w/ Qualifying Biometrics	FREE *Value: $385*	*New and improved program* taught by Marcia Upson, ARNP, this 10-week online course is geared towards slowing the progression of disease by reducing Metabolic Syndrome factors, including diabetes, obesity, and cardiac health. Apply at www.naturallyslim.com/spencerhospital
Quit Line Iowa Tobacco Cessation		*Contact Employee Health at 264-6636*
All Employees & Spouses	FREE *Value: $350*	Series of five, smoking cessation calls through Quit Line Iowa.
Athletic Enhancement Discount		*Contact Tim or Jason in Athletic Enhancement at 264-6633*
All Employees with Budgeted hours and their Spouses	FREE** ***Tax implications may apply*** *Value: $480 yr/ each*	AE is accessible 24/7 and personal training programs are available. *enrollment fee/each & free thereafter
Miscellaneous Wellness Extras		*Contact Candace in HR at 264-6643*
All Employees	FREE	Indoor and outdoor walking paths. We occasionally offer different walking challenges in our walking paths and stairwells.
CT Cardiac Score or Ultrasound Stroke Screening (one per calendar year)		*Contact Diagnostic Imaging at 264-6500*
All Employees & Spouses ***Men 40+ years; Women 45+ years***	$10 each *Value: $75/each*	A cardiovascular risk identification and reduction program operated by Spencer Hospital. Must meet appropriate age and other criteria.
Flu Vaccine		*Contact Employee Health at 264-6636*
All Employees	FREE *Value: $35*	It is highly recommended that all Spencer Hospital employees receive the influenza vaccine annually through the Employee Health, especially employees who provide direct patient care.
Ongoing Wellness Contests		*Contact Candace in HR at 264-6643*
All Employees ***Ongoing***	FREE	Participate in various wellness challenges and activities provided by the Spencer Hospital Wellness Committee. Previous challenges include: Water challenges, Aging Backwards challenges, Veggie Trays during the holidays, and more! Check your email to hear first the latest.

Questions? *Call Human Resources at (712) 264-6205*

DENTAL INSURANCE

Delta Dental

If you use PPO providers, you will receive greater benefits. To locate a preferred provider visit www.deltadentalia.com or call (800) 544-0718.

Type of Service	PPO	Premier	Out-of-Network
Deductible	$50/person	$75/person	$100/person
Plan Maximum*	$1,000 Annual maximum w/ Carryover-To-Go		
Diagnostic & Preventive Services *Deductible waived* Dental cleanings Oral evaluation Fluoride application X-rays Space maintainers Sealant applications	$0 deductible, 0% coinsurance	$0 deductible, 10% coinsurance	$0 deductible, 30% coinsurance
Routine & Restorative Services *Deductible applies* Cavity repair Tooth extractions Emergency treatment General anesthesia/sedation Restoration of decayed or fractured teeth Limited occlusal adjustment Routine oral surgery	$50 deductible, 20% coinsurance	$75 deductible, 30% coinsurance	$100 deductible, 50% coinsurance
Major Services *Deductible applies* Root Canals Gum & Bone Diseases High Cost Restoration-crowns, inlays, onlays Dentures, bridges and implants	$50 deductible, 50% coinsurance	$75 deductible, 50% coinsurance	$100 deductible, 60% coinsurance
Orthodontia *Deductible waived* (Covers dependents to the age of 26 and adults)	$0 deductible, 50% coinsurance	$0 deductible, 50% coinsurance	$0 deductible, 50% coinsurance
Orthodontia Lifetime Maximum	$1,000		
EMPLOYEE COST	**Pay Period**		
Employee	$12.50		
Employee/Spouse	$25.00		
Employee/Child(ren)	$25.00		
Family	$42.50		

*12 month waiting period for late entrant applies

VISION INSURANCE

MetLife

If you use in-network providers, you will receive greater benefits. To locate an in-network provider visit www.metlife.com/mybenefits or call (855) 638-3931.

Type of Service	In-Network	Out-of-Network Reimbursement
Exam	$10 Copayment	Up to $45
Materials	$10 Copayment	n/a
Frames	$150 retail allowance with an additional 20% off balance ($85 Costco allowance)	Up to $70
Standard Lenses -Single -Bifocal -Trifocal -Lenticular -Progressive Standard	 $10 Copayment $10 Copayment $10 Copayment $10 Copayment Up to $55 Copayment	 Up to $30 Up to $50 Up to $65 Up to $100 Up to $50
Contact Lenses (in lieu of frame and spectacle lenses) -Contact fitting and evaluation -Elective Contacts -Medically Necessary Contacts	 $60 Maximum Copayment $150 Allowance Covered in Full after eyewear copay	 Up to $105 Up to $210
Lasik Vision	15% off regular price or 5% off a promotional offer	N/A
Frequency -Eye Exam -Lenses or contact lenses -Frame	 Once every 12 months Once every 12 months Once every 24 months	

EMPLOYEE COST	Pay Period
Employee	$4.22
Employee/Spouse	$8.46
Employee/Child(ren)	$7.16
Family	$11.81

FLEXIBLE SPENDING ACCOUNTS (FSA)

WEX

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Plan Overview

Pre-Tax Premium Benefits

This plan allows you to fund several of your premium contributions with pre-tax dollars and to fund either a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Your contributions are deducted from your gross wages before FICA, Federal and State taxes are deducted. You save money because you are taxed at a reduced income level. Your taxes are calculated after your premiums and reimbursement account monies are deducted from your gross wages.

Health Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Health Care Reimbursement Account to pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. Some examples include:

- Deductible, coinsurance and copayments
- Over the counter medications – with prescription
- Dental services and orthodontia
- Vision services, including contact lenses, contact lens solution, eye exams and eyeglasses
- Hearing services, including hearing aids and batteries

Medical Care Maximum: $3,050

Limited Purpose Account

If you are contributing to an HSA you are eligible to use the Health Care Reimbursement Account for vision and dental expenses only.

Limited Purpose Maximum: $3,050

Dependent Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Dependent Care Reimbursement Account. You may request reimbursement as you incur expenses to provide day care for qualified dependents: children under age 13, or an older disabled dependent child, or a disabled adult.

Dependent Care Maximums: $5,000 if married filing jointly or head of household; $2,500 if married filing single.

Plan Provisions

Please Note: Your election in the Spencer Hospital Section 125 Flexible Benefit Plan is irrevocable for the entire plan year (January 1st through December 31st) without a qualifying change in status (i.e. birth, adoption, divorce, job status change, etc.) Please be advised that any unused FSA monies over $610 will be forfeited back to the Plan at the end of the plan year.

Claim Submission

Claims may be filed by mailing, faxing, or online. Please be aware that your plan has a 90-day run out period, after the end of the plan, where you may still file claims. Remember that the expense, however, must have been incurred during the plan year.

Claim Processing

Claims are processed on a daily basis. Reimbursements may be automatically deposited into your checking account or mailed to you in the form of a check.

FLEXIBLE SPENDING ACCOUNTS

How do Flexible Spending Accounts Work?

Flexible Spending Accounts (FSAs) are like personal bank accounts. They allow you to set aside money for healthcare and/or dependent care expenses on a pre-tax basis. You can enroll in a Healthcare FSA and/or a Dependent Day Care FSA. Your election will cover you from your enrollment date through the end of the plan year unless you have a change in family status.

You can elect to have a portion of your salary withheld on a pre-tax basis for health or dependent care expenses you incur during the plan year. The funds will be placed into an account to be used during the year. If you contribute to both FSAs, you cannot use amounts contributed to one account to pay expenses eligible for payment from another account. For example, you cannot pay medical expenses from your Dependent Day Care FSA.

Health Care FSA

During annual enrollment, you may elect to contribute monies into the Health Care FSA during the coming plan year. The amount you elect to set aside will be deducted from your paycheck in equal installments during the plan year.

Eligible health care expenses include copayments, deductibles, coinsurance, certain orthodontic procedures and other health-related expenses incurred by you or a family member. In addition, over-the-counter medicines are eligible for reimbursement with a prescription.

Dependent Care FSA

You can contribute up to $5,000 each year to the Dependent Day Care FSA to pay for dependent care expenses. The amount you elect to set aside will be deducted from your paycheck in equal installments during the coming year.

Eligible expenses are only those incurred for the care of a child under 13 years of age (or a disabled child older than age 13) who qualifies as your dependent for tax purposes; or, anyone you can claim as a dependent, such as an elderly parent or disabled spouse.

Use It or Lose It

It is very important that you estimate accurately when determining how much to contribute to either FSA. FSAs can provide significant tax advantages for employees when the contributions are made on a pre-tax basis. For this reason, the IRS requires that you use all of the money in your account(s) during the plan year. Any money remaining in your account(s) over $610 at the end of the plan year will be forfeited.

FSA TAX SAVINGS WORKSHEETS

What will you do with the money you save by participating in the Flex Plan?

Use this worksheet to help determine your potential tax savings.

FSA Reimbursement Account Expenses							
Medical		**Vision**		**Dental**		**Dependent Care**	
Deductibles	$	Exams	$	Routine Exam	$	Children	$
Copays	$	Eye Surgery	$	Fillings/ Crowns	$	Adults	$
Prescriptions	$	Lenses/ Frames	$	Orthodontics	$		
Other	$	Contacts	$	Other			
Total	$	Total	$	Total	$	Total	$

Estimated Annual Expenses & Tax Savings		
Total Medical + Vision + Dental Expenses		$
Total Dependent Care Expenses	+	$
Total Expenses		$
Tax Bracket Percentage (see below)	X	
Annual Tax Savings		$
Number of Pay Periods	/	
Estimated Savings Per Pay Check		$

Tax Estimate Table	
Annual Household Earnings*	**Estimated Tax Rate**
$0 - $20,550	10%
$20,551-$83,550	12%
$83,551 - $178,150	22%
$178,151 - $340,100	24%
$340,101 - $431,900	32%
$431,901 - $647,850	35%
> $647,851	37%

*married, filing jointly

WEX Benefits Card

Our benefits debit card is the fastest and most convenient way to access your funds and pay for eligible expenses. Just one debit card is all you need for your card-eligible benefits with us.

While the IRS requires documentation for certain spending and reimbursement benefits, we automate some of that substantiation through:

IIAS approval: If a merchant uses the Inventory Information Approval System (IIAS), the debit card will automatically approve eligible expenses. You can view a list of IIAS merchants at www.sig-is.org/card-holders/store-locator.

Copayments: If your employer provides us copayment amounts for your insurance plans, we can auto-approve expenses that match these copayment amounts.

Recurring claims: If you use your debit card for a purchase that requires substantiation, once the claim has been approved and you make that same purchase for the same dollar amount at that merchant, the recurring claim will be automatically approved.

How do I get a card?

We'll automatically mail you two debit cards to the address listed in your account the first time you enroll. If you're already enrolled, continue using the debit card you have.

Additional cards

You can request additional debit cards for your spouse or dependents from your online account. Log in, under Accounts select "Banking/Cards.

Expiring debit card

We will automatically mail you a new debit card 30 or more days prior.

Lost or stolen cards

If your debit card is lost or stolen, you can report it in your online account or mobile app and request a new card.

Benefits Mobile App

Access your benefits anytime, anywhere

Access your benefits on the go 24/7 with the WEX benefits mobile app. Our free app gives you convenient, real-time access to all your benefits accounts in one spot. This makes it easy to use your hard-earned dollars and view recent account activity without ever needing to call in.

The benefits mobile app keeps your benefits always within reach. Want to know the status of a recent claim or easily check the balance of your accounts? Log in to our secure app to get answers to those questions and so many more — wherever and whenever you want.

With our benefits mobile app, you can:

Get instant updates on the status of your claims.

File a claim and upload documentation in seconds using your phone's camera.

Report a card as lost or stolen, which cancels the card and ships you a new one.

Log in through face recognition or fingerprint (depending on your phone).

Check your balance and view account activity.

Use your benefits debit card directly from your mobile phone with Apple Pay or Samsung Pay.

Scan an item's bar code to determine if it's an IRS code section 213(d) eligible expense.

Reset login credentials.

Security on the go

Our mobile apps use encryption and won't store photos, keeping your documentation safe and secure.

Download the app for free on Apple and Android smartphones and tablets

Download on the App Store

GET IT ON Google Play

Simplifying benefits for everyone.

BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

SunLife

Plan Overview

Basic Benefit Amount
1x Annual Salary up to $500,000

Accidental Death Benefit
Amount is the same as the Basic Life amount.

Waiver of Premium
Life insurance continues for totally disabled employees without payment of premium if:

- Disability begins while the employee is insured;
- Disability begins prior to age 60 and terminates at age 65;
- Proof of disability is given to Carrier, prior to the end of the Disability Elimination Period;
- Proof of continued disability is verified periodically, according to the terms of the contract.

Living Care Benefits
If you have a qualifying medical condition, you may apply for an accelerated benefit to receive a portion of your life insurance once *during your lifetime*. Amount of benefit: 75% of the Life Insurance in force, but not to exceed $500,000.

Conversion
Must apply for conversion within 31 days of termination of policy.

Age Reduction Schedule
Coverage reduces to 50% at age 70
Benefits terminate at retirement

VOLUNTARY TERM LIFE INSURANCE

SunLife

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself, you may also elect coverage on your dependents in this benefit, you pay the full cost through payroll deductions.

Voluntary Coverage Amounts

Employee may elect up to 1 or 2 times his/her annual salary

Minimum: 1x or 2x Annual Salary
Maximum: $500,000

Spouse may be covered for up to 50% of the employee amount to $250,000

Minimum: $5,000
Maximum: $250,000
Multiples of: $5,000

Child(ren)

Minimum: $5,000
Maximum: $10,000
Multiples of: $5,000

Guarantee Issue Amounts[(1)]

Employee: $200,000
Spouse: $25,000
Child(ren): $10,000

Waiver of Premium

Life insurance continues for totally disabled employees without payment of premium if:

- Disability begins while the employee is insured;
- Disability begins prior to age 60 and terminates at age 70;
- Proof of disability is given to Carrier, prior to the end of the Disability Elimination Period;
- Proof of continued disability is verified periodically, according to the terms of the contract.

Portability

Apply for within 31 days of termination.

Age Reduction Schedule

At age:	Benefits reduce to:
70	50%

[(1)]The levels of Guarantee Issue (GI) coverage are available for employees & family members when the employee is initially eligible. At later annual enrollment periods, all applications for coverage are subject to approval by the carrier.

Monthly Cost for Each $1,000 of Employee & Spouse Life/AD&D Insurance Coverage

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee	$0.036	$0.054	$0.072	$0.09	$0.135	$0.207	$0.297	$0.387	$0.927	$1.494
Spouse	$0.072	$0.072	$0.081	$0.126	$0.180	$0.288	$0.468	$1.215	$1.215	n/a
Children	$.225 per $1,000									

MATCHING YOUR LIFE INSURANCE TO YOUR NEEDS

The primary role of life insurance is to provide money for your family if you should die. As a first step in making your life insurance election, you'll want to look at your family's needs and determine the coverage amount that would be necessary to meet those needs if you were to die today.

1 You can start by figuring out the annual living expenses for your survivors. Experts suggest that their needs will probably equal about 75% of your current expenses. You may prefer to enter a different amount, depending on what you believe your survivors will need.

$ _____

Current Annual Expenses

X .75

$ _____

Survivor's Annual Expenses

+

2 Next, consider any future annual expenses that may come into play, such as college tuition. Add this amount to the current annual expenses.

$ _____

-

3 Subtract any annual income you expect your survivors to receive. This might include a spouse's income or Social Security or pension plans, if applicable.

$ _____

Estimated Annual Income Benefits

4 The result is an estimate of the amount your family would require to meet their ongoing needs.

$ _____

Estimated Amount to be Replaced by Life Insurance

SHORT TERM DISABILITY INSURANCE

Spencer Hospital

Short Term Disability Income Benefits

Spencer Hospital provides Full-time, Part-Time and Weekend Package benefit eligible employees with short term disability income benefits, and pays the full cost of this coverage. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits. Effective for new employees after one full year of employment.

Plan Overview	
Benefits Begin	24 Hour Injury 24 Hour Sickness
Maximum Benefit Period	13 Weeks
Percentage of Income Replaced	60% of Weekly Earnings
Exclusions	Benefit does not cover work-related accidents or injuries.
Pre-existing Condition Waiting Period	Not Applicable.

LONG TERM DISABILITY INSURANCE

SunLife

Long Term Disability Income Benefits

Spencer Hospital provides Full-Time, Part-Time and Weekend Package benefit eligible employees with long term disability income benefits and pays the full cost of this coverage. In the event you become disabled, disability income benefits are provided as a source of income. Effective for new employees after 90 days of employment.

Plan Overview	
Class Description	Class 1: Executives Class 2: Part-time and full-time employees
Benefit Amount	60% of monthly salary
Own Occupation Period	2 years
Elimination Period	90 days
Maximum Benefit Period	Varies based on the age disability occurs. Refer to your summary plan description for details
Maximum Benefit Amount	Class 1: $15,000 and Class 2: $6,000
Survivor Benefit	3 months
Zero Day Residual	Zero day residual stipulates that full-time or part-time work in which the employee is performing all of the material duties of his or her regular, or some other occupation, will not interrupt the qualifying (elimination) period, or the period of disability
Pre-Existing Condition Waiting Period	3/12 applies to all employees covered less than 12 months. In the event of a claim, the carrier will review information from 3 months prior to the employee being insured on this plan; if the disabling condition had been treated or diagnosed, there would be no LTD benefits for the first 12 months. After that time, benefits will be payable according to the terms of the contract.

Accident Insurance

Sun Life

You can purchase this coverage for you and your family. Child coverage is available to age 26.

HELPS YOUR FINANCES AFTER A MISHAP.

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

PAYS CASH BENEFITS DIRECTLY TO YOU.

Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

ACCIDENT FAST FACTS

Falls *are the leading cause of injuries treated in emergency rooms every year, for people of all ages.*[1]

This coverage pays benefits whether your covered accident happens at work, at home, or away (also known as 24-hour coverage).

SPENCER MUNICIPAL HOSPITAL

All Eligible Employees

POLICY # 955748

Sun Life Assurance Company of Canada

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Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here. Choose the plan that best meets your needs and your budget.

DISLOCATIONS	LOW PLAN		HIGH PLAN	
	OPEN (SURGERY)	CLOSED (NO SURGERY)	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$2,000	$1,000	$4,000	$2,000
Knee, ankle, or bones of the foot	$1,000	$500	$2,000	$1,000
Elbow, wrist or Lower jaw	$400	$200	$800	$400
Shoulder	$500	$250	$1,000	$500
Collarbone or bones of the hand	$800	$400	$1,600	$800
Finger(s) or toe(s)	$100	$50	$200	$100
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$2,000	$1,000	$4,000	$2,000
Skull-depressed	$3,000	$1,500	$6,000	$3,000
Skull-simple	$1,500	$750	$3,000	$1,500
Vertebral processes, Bones of the face or Nose	$350	$175	$700	$350
Leg	$1,000	$500	$2,000	$1,000
Vertebrae, Sternum or Pelvis	$800	$400	$1,600	$800
Upper jaw or upper arm	$375	$190	$750	$375
Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$325	$170	$650	$325
Rib, Finger, Toe or Coccyx	$175	$90	$350	$175
Multiple ribs	$500	$250	$1,000	$500
ADDITIONAL INJURIES				
Eye Injury - surgical repair		$125		$250
Eye Injury - object remove		$125		$250
Gunshot wound		$250		$500
Paralysis—paraplegia		$5,000		$25,000
Paralysis—quadriplegia		$10,000		$50,000
Coma		$5,000		$10,000
Concussion		$200		$300
BURNS	**2ND DEGREE**	**3RD DEGREE**	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$200	$500	$400	$1,000
41-65 square centimeters	$400	$1,000	$800	$2,000
66-160 square centimeters	$600	$3,000	$1,200	$6,000
161-225 square centimeters	$800	$7,000	$1,600	$14,000
More than 225 square centimeters	$1,000	$10,000	$2,000	$20,000
Skin graft	50% of the applicable Burn Benefit		50% of the applicable Burn Benefit	
LACERATIONS				
No sutures and treated by doctor		$20		$35
Single laceration under 5 cm with sutures		$35		$65
5-15 cm with sutures (total of all lacerations)		$125		$250
Greater than 15 cm with sutures (total of all lacerations)		$250		$500

MEDICAL SERVICES		
Diagnostic Exam. -. Arteriogram,. Angiogram,. CT,. CAT,. EKG,. EEG,. or. MRI. (1 time. per. benefit year)	$100	$200
Diagnostic Exam. -. X-ray. (1. time. per. covered. accident)	$50	$100
Accident Emergency. Treatment,. non-emergency. room. (once. per covered. accident)	$25	$50
Physician's. Follow-up. Treatment. office. visit. (per. visit,. up. to. 6. times. per covered. accident)	$75	$100
Physical. Therapy. (per. visit. up. to. 10. visits. per. covered. accident)	$25	$25
Medical. Devices	$400	$500
Epidural. Pain. Management. (up. to. 2. times. per. covered. accident)	$50	$100
Prescription. drug	$35	$50
Prosthesis. (one)	$250	$500
Prosthesis. (two)	$500	$1,000
Blood,. Plasma,. or. Platelet. Transfusion	$300	$400
HOSPITAL		
Hospital. Admission. (once. per. benefit. year)	$1,000	$2,000
Hospital. Confinement. (per. day. up. to. 365. days. per. covered. accident)	$300	$400
Intensive. Care. Unit. Admission. (once. per. Benefit. Year;. payable. instead. of Hospital. Admission. benefit. if. Confined. immediately. to. ICU)	$1,500	$2,000
Intensive. Care. Unit. Confinement. (per. day. up. to. 14. days,. payable. in addition. to. any. Hospital. Confinement. benefit)	$300	$500
Ambulance. (Ground)	$200	$300
Ambulance. (Air)	$750	$1,000
Emergency. Room. Admission	$150	$200
Family. Lodging. (per. day. up. to. 30. days. per. benefit. year)	$50	$100
Transportation. (100. or. more. miles. up. to. 3. times. per. covered. accident)	$250	$500
Rehabilitation. Unit. (per. day. up. to. 30. days. per. covered. accident)	$50	$100
SURGERY		
Miscellaneous. Surgery. requiring. general. anesthesia. (not. covered. by. any other. benefit)	$150	$300
Open. Surgery	$625	$1,250
Exploratory. Surgery. or. Debridement	$125	$250
Tendon/Ligament/Rotator. Cuff. Tear	$300	$625
Torn. Knee. Cartilage	$300	$625
Ruptured/Herniated. Disc	$300	$625
EMERGENCY. DENTAL		
Emergency. Dental extraction	$50	$100
Emergency. Dental crown	$100	$200
WELLNESS		
Wellness. Screening. Benefit (once. per. benefit. year)	$100	$100

LIFE AND. DISMEMBERMENT. LOSSES*	LOW PLAN	HIGH PLAN
Accidental Death	$25,000	$50,000
Accidental Death. Common. Carrier. (pays. an. additional benefit. if. accidental death. occurs. while. traveling. as. a. fare-paying. passenger. on. a. public. conveyance)	$50,000	$150,000
Catastrophic. Loss:. . Both. arms. or. both. hands,. both. legs. or. both. feet,. one. hand. and. one. foot. or. one. arm. and. one. leg,. or. irrecoverable. loss. of. sight. of. both. eyes	$7,500	$15,000
Loss. of. one. hand,. foot,. leg,. or. arm	$2,500	$7,500
Loss. of. sight. of. one. eye. or. loss. of. one. eye	$3,750	$7,500
Two. or. more. fingers. or. toes	$500	$1,000
One. finger. or. one. toe	$250	$500

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 100% of the employee benefit amount for dismemberment. Dependent children benefits are 50% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

Frequently asked questions

How do I file an accident claim?
If you have an accident after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about the accident and the treatment provided.

What happens once my claim is approved?
The benefit amount you receive will depend on your injury and/or the treatment provided. Remember, benefits are payable only once for each covered accident, unless noted otherwise in the benefit schedule.

Is there a time period that I need to follow?
Injuries and other related benefits due to a covered accident must be diagnosed or treated within a defined period of time from the date of your accident. This could be as few as three days for certain benefits. Please refer to your Certificate for details.

How do I get the Wellness Screening Benefit?
You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests and cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). Our wellness screening benefit claim form can also be downloaded from our website.

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Is my benefit taxable?
If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Accident insurance is a limited benefit policy. The Certificate has exclusions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of your Certificate.

1. "Health, United States, 2016," US Department of Health and Human Services, Table 75.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Accident

We will not pay a benefit that is due to or results from: suicide while sane or insane; intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); incarceration; engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering; participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating; injuries sustained from commercial air transportation other than riding as a fare paying passenger; work-related illness or injuries unless you are enrolled in 24-hour coverage.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVBH-EE-8384 SLPC 29579

Rates

Coverage and **semi-monthly** cost for Accident.
Rates are effective as of January 1, 2023.
Accident coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Low plan:

Coverage	Cost per pay period*
Employee	$3.40
Employee + Spouse	$5.20
Employee + Child(ren)	$7.17
Employee + Family	$8.97

High plan:

Coverage	Cost per pay period*
Employee	$5.38
Employee + Spouse	$8.22
Employee + Child(ren)	$11.24
Employee + Family	$14.08

*Contact your employer to confirm your part of the cost.

Critical Illness Insurance

Sun Life

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis and treatment options.

BENEFITS *(You can purchase this coverage at a group rate.)*	
For you	You can choose between **$10,000** and **$40,000** of coverage, in increments of $10,000. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose between **$10,000** and **$40,000** of coverage, in increments of $10,000. No medical questions asked. Not to exceed 100% of your coverage amount.
For your child(ren)	If you elect coverage for yourself, you can choose between **$5,000** and **$20,000** of coverage, in increments of $5,000. No medical questions asked. Not to exceed 50% of your coverage amount. An eligible child is defined as your child from birth to age 26.

SPENCER MUNICIPAL HOSPITAL

All Eligible Employees

POLICY #: 955748

What's covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*

Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis
Childhood Conditions *Applies to dependent children only*	Down Syndrome Cystic Fibrosis Type 1 Diabetes Mellitus Complex Congenital Heart Disease	Cerebral Palsy Cleft Lip/Palate Muscular Dystrophy Spina Bifida
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	..... Employee $50 ..... Spouse $50 ..... Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 12 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

What if I have a pre-existing condition?

If you are diagnosed with a covered critical illness within 6 months of your insurance taking effect or 6 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. In order to receive benefits for more than one critical illness, there must be at least 6 consecutive months between each diagnosis date. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

How is my benefit taxed?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

CRITICAL ILLNESS FAST FACT

*Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.***

**"What Are Your Odds of a Heart Attack?" health.com, June 2018.

Critical Illness insurance is a limited benefit policy. The certificate has exclusions, limitations and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Critical Illness

We will not pay a benefit that is due to or results from services, treatment or complications not included in the Benefit Highlights; provided by an immediate family member; or unrelated to a Critical Illness/Specified Disease. These include an autologous bone marrow transplant, suicide, attempted suicide or intentionally self inflicted injuries, elective plastic or cosmetic surgery, active military duty, war, any act of war, or your active duty in any armed service during a time of war (excluding during acts of terrorism); your active participation in a riot, rebellion or insurrection; committing or attempting to commit an assault, felony or other criminal act; engaging in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury; being incarcerated in a penal institution of any kind; being legally intoxicated or under the influence of any narcotic, unless taken on the advice of a physician and taken as prescribed.

Covered conditions have specific diagnostic criteria that must be met (along with supporting documentation) for a benefit to be paid. For additional information regarding covered conditions, please request an outline of coverage.

This product is inappropriate for individuals who are eligible for Medicaid coverage.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of insurance. The cost is included in the total amount billed. HealthChampion℠(a health care support service) is not insurance and is provided by ComPsych®. ComPsych® is a registered trademark of ComPsych Corporation. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVBH-EE-8384 SLPC 29579

Rates

Rates are effective as of January 1, 2023.

The chart below shows possible coverage amounts and their **semi-monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Employee Critical Illness - Choice 1 Non-tobacco rates | Age and cost - pay period (semi-monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	3.05	3.15	3.60	4.25	5.60	7.10	9.00	11.50	15.30	20.95	30.50	30.50
$20,000	6.10	6.30	7.20	8.50	11.20	14.20	18.00	23.00	30.60	41.90	61.00	61.00
$30,000	9.15	9.45	10.80	12.75	16.80	21.30	27.00	34.50	45.90	62.85	91.50	91.50
$40,000	12.20	12.60	14.40	17.00	22.40	28.40	36.00	46.00	61.20	83.80	122.00	122.00

Employee Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (semi-monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	3.50	3.60	4.50	5.60	8.00	10.80	14.30	18.80	10.45	35.80	52.75	52.75
$20,000	7.00	7.20	9.00	11.20	16.00	21.60	28.60	37.60	20.90	71.60	105.50	105.50
$30,000	10.50	10.80	13.50	16.80	24.00	32.40	42.90	56.40	31.35	107.40	158.25	158.25
$40,000	14.00	14.40	18.00	22.40	32.00	43.20	57.20	75.20	41.80	143.20	211.00	211.00

Rates

Rates are effective as of January 1, 2023.

The chart below shows possible coverage amounts and their **semi-monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Spouse rates are based on the employee's age.

Spouse Critical Illness - Choice 1 Non-tobacco rates | Age and cost - pay period (semi-monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	2.70	2.95	3.05	3.50	4.25	5.40	7.10	9.35	12.70	17.35	22.95	22.95
$20,000	5.40	5.90	6.10	7.00	8.50	10.80	14.20	18.70	25.40	34.70	45.90	45.90
$30,000	8.10	8.85	9.15	10.50	12.75	16.20	21.30	28.05	38.10	52.05	68.85	68.85
$40,000	10.80	11.80	12.20	14.00	17.00	21.60	28.40	37.40	50.80	69.40	91.80	91.80

Spouse Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (semi-monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	2.95	3.05	3.50	4.30	5.65	7.75	10.70	14.75	20.90	29.15	39.05	39.05
$20,000	5.90	6.10	7.00	8.60	11.30	15.50	21.40	29.50	41.80	58.30	78.10	78.10
$30,000	8.85	9.15	10.50	12.90	16.95	23.25	32.10	44.25	62.70	87.45	117.15	117.15
$40,000	11.80	12.20	14.00	17.20	22.60	31.00	42.80	59.00	83.60	116.60	156.20	156.20

Rates are effective as of January 1, 2023.

The chart below shows possible coverage amounts and their **semi-monthly** costs.

Child(ren) Critical Illness - Choice 1

Coverage amounts	Cost - pay period (semi-monthly) premium
$5,000	1.48
$10,000	2.95
$15,000	4.43
$20,000	5.90

Hospital Indemnity Insurance

Sun Life

HELPS PROTECT YOUR FINANCES.
When you, your spouse or child are facing a hospital stay, you can receive a benefit to help pay unexpected expenses not covered by your plan.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with an illness or injury, you can use your hospital indemnity benefits to help cover related expenses like lost income, child care, deductibles and copays.

PAYS CASH BENEFITS DIRECTLY TO YOU.
Hospital Indemnity insurance payments can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you.

You can purchase this coverage for you and your family. Child coverage is available to age 26.

BENEFITS	
Benefits are payable for hospital stays due to:	• Sickness • Accidents* • Routine pregnancy • Complications of pregnancy • Newborn complications • Mental and nervous disorders • Substance abuse
Additional reasons to sign up:	• No medical questions to answer - guaranteed issue coverage • Benefits add up - many of your benefits can all be payable on the same day

Your employer is offering you a choice of two plans. Please review the information for both plans. Then, choose the one plan that best fits your needs.

*Confinements due to an accident must be within 365 days of the accident.

SPENCER MUNICIPAL HOSPITAL

All Eligible Employees

POLICY # 955748

What's covered – LOW

This plan provides benefits due to hospital stays for covered accidents or sickness. Once your Hospital Indemnity coverage goes into effect, you can file a claim for covered hospital stays occurring after your plan's effective date.

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

BENEFIT SCHEDULE – LOW

FIRST DAY BENEFITS Payable per benefit year	**LOW**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$500 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$500 per day 1 day
CONFINEMENT BENEFITS Payable per benefit year	**LOW**
Hospital confinement – This benefit pays for a hospital stay in a standard room. Payable with: • *First day hospital confinement benefit*	$100 per day Up to 15 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay. Payable with: • *First day hospital confinement benefit* • *Hospital confinement benefit*	$100 per day Up to 15 days
ADDITIONAL AND ENHANCED BENEFITS Payable per benefit year	**LOW**
Extended hospitalization benefit – This additional benefit pays after 10 total days in a row of confinement beginning with your first day in: • a regular hospital room • the ICU	$100 per day
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

What's covered – HIGH

This plan provides benefits due to hospital stays for covered accidents or sickness. Once your Hospital Indemnity coverage goes into effect, you can file a claim for covered hospital stays occurring after your plan's effective date.

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

BENEFIT SCHEDULE – HIGH

FIRST DAY BENEFITS Payable per benefit year	**HIGH**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$1,000 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$1,000 per day 1 day
CONFINEMENT BENEFITS Payable per benefit year	**HIGH**
Hospital confinement – This benefit pays for a hospital stay in a standard room. Payable with: • *First day hospital confinement benefit*	$200 per day Up to 15 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay. Payable with: • *First day hospital confinement benefit* • *Hospital confinement benefit*	$200 per day Up to 15 days
ADDITIONAL AND ENHANCED BENEFITS Payable per benefit year	**HIGH**
Extended hospitalization benefit – This additional benefit pays after 10 total days in a row of confinement beginning with your first day in: • a regular hospital room • the ICU	$200 per day
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

Frequently asked questions

What benefits will I receive for my newborn child?
If your newborn has to stay in the Neonatal Intensive Care unit (NICU), benefits are payable. Hospital stays for routine newborn care are not covered.

How do I file a Hospital Indemnity claim?
If you are confined to the hospital after the effective date of coverage, you can file a claim with us by downloading forms from our website. You will need to provide information about your hospital stay.

Do I need to file my claim within a certain timeframe?
You should file your claim within 30 days of a covered confinement or as soon as reasonably possible.

How do I get the Wellness Screening Benefit?
You can receive payment if you or a family member have a covered screening test or exam. This benefit is payable each year for specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can be downloaded from our website.

Is my benefit taxable?
If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your option.

Please read the *Important information* section of this document.

Helpful definitions

Benefit year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Confinement means resident inpatient stay in a hospital for at least 20 continuous hours. There must be a charge for room and board unless it is a Veteran's Administration Hospital or other federal government operated hospital.

Hours spent in an observation unit are not eligible for the *First day hospital* or *First Day ICU confinement* benefit. An observation unit stay of 20 hours or more will be covered under the Hospital confinement benefit.

Confinement does not include the period of time in a hospital emergency room, observation room, a freestanding surgical facility or an outpatient facility.

Covered Accident means an accident that the policy or applicable riders or endorsements attached to it does not exclude.

Covered Sickness means a sickness that the policy or applicable riders or endorsements attached to it does not exclude.

Hospital means a licensed facility that provides inpatient medical care and treatment to sick and injured persons with 24-hour nursing service under the supervision of a physician. Hospital does not include a rest home; a skilled nursing facility; an extended care facility; a place of convalescence; a rehabilitation unit; a hospice facility; a place providing custodial care; a mental and nervous disorder facility or a substance abuse facility.

Intensive Care Unit (ICU) means a specifically designated part of a hospital that provides the highest level of medical care. It is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care, including a neonatal intensive care unit specializing in the care of ill or premature newborn infants. The ICU must be under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis and have an assigned physician on a full-time basis. An ICU is not a progressive care unit; an intermediate care unit; a private monitored room; sub-acute intensive care unit or an observation unit.

Inpatient or Inpatient Treatment means receiving treatment as a resident patient using, and being charged for, the room and board facilities of a hospital. The requirement that you be charged does not apply to confinement in a Veteran's Administration Hospital or other federal government operated hospital.

Observation Unit means a specified area within a hospital, apart from the Emergency Room, where a patient can be monitored by a physician and which is under the direct supervision of a physician or registered nurse; is staffed by nurses assigned specifically to that unit; and provides care seven days per week, 24 hours per day.

An observation unit stay lasting 20 hours or more is treated as a Hospital confinement.

Rehabilitation Unit means a distinct unit within a hospital that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of multidisciplinary physical restorative services to achieve the highest possible functional ability for disability due to sickness or injury. Services are provided by or under the supervision of a trained and experienced rehabilitation physician. A rehabilitation unit is not a freestanding rehabilitative facility; a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice facility; a facility for the treatment of alcoholism or drug addiction or an assisted living facility.

Important information

This is a limited benefit policy. It does NOT provide basic hospital, basic medical, or major medical insurance. It is not a Medicare Supplement policy. The certificate has exclusions, limitations, and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate. The policy, certificate and any rider, if applicable, may not be available in all states and may vary based on state laws and regulations. This product is inappropriate for individuals who are eligible for Medicaid coverage.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to the Certificate for details.

Exclusions

The exclusions listed below may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Hospital Indemnity

No benefits will be payable relating to or resulting from services or treatment rendered or confinement outside the United States or Canada. No benefits will be payable for any loss that is caused or contributed to by: war or any act of war or your active duty in any armed service during a time of war (this does not include acts of terrorism); active military duty; riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated; committing of or attempting to commit an assault, felony or other criminal act; active participation in a riot, rebellion or insurrection; committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally; incarceration in a penal institution of any kind; elective abortion or complications thereof; elective or cosmetic surgery or procedures, except for reconstructive surgery unless due to congenital anomaly or disease of a dependent child which has resulted in a defect; artificial insemination, in vitro fertilization, test tube fertilization; or sterilization, tubal ligation or vasectomy, and reversal thereof, unless recommended by a physician.

GVBH-EE-8384

SLPC 29579

Rates

Coverage and **semi-monthly** cost for Hospital Indemnity.

Rates are effective as of January 1, 2023.

Hospital Indemnity coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Low plan

Coverage	Cost per pay period*
Employee	$6.88
Employee + Spouse	$11.91
Employee + Child(ren)	$11.05
Employee + Family	$16.07

High plan

Coverage	Cost per pay period*
Employee	$12.92
Employee + Spouse	$22.35
Employee + Child(ren)	$20.75
Employee + Family	$30.18

*Contact your employer to confirm your part of the cost.

EFR EMPLOYEE & FAMILY RESOURCES

CORE EAP BENEFIT SUMMARY

Spencer Hospital

Maintaining work-life balance is more stressful than it's ever been. An Employee Assistance Plan (EAP) provides a variety of counseling, consultations, resources, and coaching benefits for you and your family members to help with small concerns, big problems, and everything in between. **Your EAP benefits are cost free to you, confidential, and available 24/7/365.** Let us help you get the services and resources you need. Here are some of issues and concerns we can help with:

- ✓ Managing Stress
- ✓ Relationship Concerns
- ✓ Personal Growth & Development
- ✓ Coping with Anxiety or Depression
- ✓ Personal Family or Legal Issues
- ✓ Caring for Elderly Family Members
- ✓ Credit Concerns and Reports
- ✓ Identity Theft Resolution
- ✓ Resources for Elder Care
- ✓ Managing Budgets and Debts
- ✓ Legal Questions & Concerns
- ✓ Tax-Related Questions

SERVICE PROVIDED	PER PERSON	SERVICES PROVIDED ARE CONFIDENTIAL AND AT NO COST TO THE COVERED PERSON
Phone-Based Support	Unlimited	Call us anytime you have an issue, concern, or question. Calls are answered by masters-leveled clinicians.
In-person Counseling	**6** Sessions per circumstance, per year	Confidential, in-person assessment and counseling with a licensed mental health therapist near your home or work location. Each member of your family is eligible for counseling services for each separate incident or set of circumstances within a rolling 12-month period. ***incidents involving multiple family members will be assessed based on specific circumstance**
Telephonic Life Coaching	**6** Sessions per year	Confidential scheduled telephonic sessions with a life coach for matters such as improving time management skills, work-life integration, goal setting, communication skills, and other areas of personal growth. Sessions renew annually.
Telephonic Financial Consultation	**1** session per issue	For each separate issue/concern a 30 minute telephonic consultation with a financial professional with expertise in the area of concern. Access to a free financial check-up, financial library and a large variety of financial tools & calculators at http://efr.clcmembers.com/.
In-Person or Telephonic Legal Consultation	**1** session per issue	For each separate issue/concern a 30 minute telephonic or in-person consultation with a licensed attorney with expertise in the area of need. If the member choses to retain the attorney for ongoing legal representation, it will be provided at 25% discount off the attorney's usual rate. Access to over 5000 free self-help (& fill-in) legal documents and a variety of other legal information is available at http://efr.clcmembers.com/. *All legal issues are covered except employment related, which are specifically excluded.*
Eldercare Resources	As needed	Information, referral resources and support for those caring for an aging parent or other family member, including connections to local resources for in-home care, alternative living arrangements, legal and financial issues and more.
Childcare Resources	As needed	Childcare resource referrals where locally available. Referrals are only to state licensed/ certified childcare providers.
Identity Theft Resolution Services	As needed	Services will be provided by a highly trained FCRA certified fraud resolution specialist (or licensed attorney) assisting with restoring identity and good credit.
Additional Benefits & Resources		*Real Life Solutions* (monthly newsletter), monthly topical live webinars, a library of previously recorded webinars and recorded benefit orientation webinars and other information is available via your HR manager or on our website www.efr.org

EFR EMPLOYEE & FAMILY RESOURCES

RETIREMENT

Iowa Public Employees' Retirement System (IPERS)

As a municipal hospital, Spencer Hospital is able to offer the Iowa Public Employees' Retirement System (IPERS) to all qualifying employees as a retirement vehicle. This defined benefit is a mandatory state retirement program designed as a supplement to Social Security.

Please contact Human Resources if you would like an enrollment booklet. You can elect this benefit at anytime throughout the year.

EMPLOYEE ELIGIBILITY: All employee classifications. (As long as certain requirements are met)

EFFECTIVE DATE FOR NEW PARTICIPANTS

Immediately upon meeting IPERS eligibility requirements.
The lifetime monthly benefit you receive is defined; it is calculated using a formula. Your benefits grow with you during your working career. The average monthly benefit paid to members retiring in the fiscal year of 2007 was $1,506.

Normal retirement age is one of the following, whichever comes first:

1) Age 65
2) Age 62 if you have 20 or more years of covered IPERS employment (60/20)
3) When your years of service plus your age equals or exceeds 88 (Rule of 88)

CONTRIBUTION LEVELS

Employee: 6.29% of covered wages through payroll deductions (Paramedics: 6.21%)
Hospital: 9.44% (Paramedics: 9.31%)

Deferred Compensation (Iowa Retirement Investor's Club)

You may participate in this tax-deferred 457 (b)tax plan, issued by Empower through the Iowa Retirement Investor's Club. Life plan funds are available. Rollover is available for qualifying 401K, 403(b), and other retirement accounts.

EMPLOYEE ELIGIBILITY: Full-time: 60-80 hours/pay period
Part-time: 40-59 hours/pay period
Casual Part-time or Weekend Package

Financial Advisors Representing Spencer Hospital

Iowa Retirement Investors' Club (RIC) 457 Deferred Compensation Plan

Employees may work with any other financial advisor appointed with MassMutual and the Iowa Retirement Investors Club plans.

Alex Johnson **Leonard Langner**	LPL Financial Corporation 122 W 5th St., Spencer, IA 51301 712-262-2600
A.J. Spielman **Kirby Froehlich**	Ameriprise Financial Services, Inc. 823 Highway Blvd. Ste. 1, Spencer, IA 51301 712-262-1777
Jeremy Eller **Kevin Hanson**	Edward Jones 323 Grand Ave., Spencer, IA 51301 712-262-0142
Richard Noah	LPL Financial Corporation 1200 W. 18th St., Ste.1, Spencer, IA 51301 712-580-5432
Levi Morris **Rian Mcgill**	Securities America Inc. 1812 Hwy. Blvd., Spencer, IA 51301 712-262-3030
Anthony (Tony) Elbert	Edward Jones 3131 Main Street, Emmetsburg, IA 50536 712-852-9074
Ronald Riha	Ameriprise Financial Services Inc. 1005 Broadway, Emmetsburg, IA 50536 ronald.f.riha@ampf.com
Tom Fuhrman	Edward Jones 1724 Hill Ave., Spirit Lake, IA 51360 712-336-4172
Richard Vander Wel	Woodbury Fin Svcs Inc 1701 Chicago Ave, Unit 101, Spirit Lake, IA 51360 712-339-9021
Bradley Schmitz	LPL Financial Corporation 1525 18th Street, Spirit Lake, IA 51360 712-332-0505
Jeffrey Vander Sluis	Principal Securities, Inc. Spirit Lake, IA 51360 712-336-5494

Revised 10-31-19

OTHER DISCOUNTS & MISCELLANEOUS BENEFITS

ATHLETIC ENHANCEMENT MEMBERSHIP

Employee and Spouse Membership- Employee pays $35 for the first month and the next monthly rate will be **waived** if the employee or spouse exercises a minimum of six workouts during each calendar month. *Tax implications of the value of the benefit may apply. Benefit available for all employees **with budgeted hours.**

GROUP INCENTIVE PROGRAM

Each fiscal year, eligible staff members may receive a bonus of up to 4% of their earnings if established patient satisfaction, employee productivity, and financial performance goals are met.

SERVICE AWARDS

Service awards are presented to employees for every five years of continuous employment with the hospital.

TUITION ASSISTANCE & EDUCATIONAL PROGRAMS

Tuition Assistance is a Spencer Hospital benefit designed to promote the personal and professional growth and development of employees. To learn more about this benefit, contact Danelle Stumbo in Human Resources Development at extension 6623.

EMPLOYEE ELIGIBILITY: Full-time: 60-80 hours/pay period
Part-time: 40-59 hours/pay period
Weekend Package

EFFECTIVE: After one year of employment

If you are a full-time employee, based on Tuition Assistance budget, awards equal up to:

- AA degree or Initial Certifying Exam: the amount of the award is 50% of the qualifying educational expenses (textbooks, travel expenses are non-qualifying expenses), up to $2,000 per fiscal year.
- Bachelor degree: the amount of the award is 75% of the qualifying educational expenses (textbooks, travel expenses are non-qualifying expenses), up to $3,000 per fiscal year.
- Graduate degree: the amount of the award is 75% of the qualifying educational expenses (textbooks, travel expenses are non-qualifying expenses), up to $4,000 per fiscal year.

EDUCATIONAL PROGRAMS

You may attend all hospital-sponsored educational programs free of charge (unless stated otherwise per program). Examples of classes include: Basic Life Saving (BLS) and Advanced Cardiac Life Support (ACLS) classes. If you are governed by continuing education requirements, you are eligible annually for eight hours of wages to attend an approved outside program.

EMPLOYEE ELIGIBILITY: All employee classifications (as long as hourly requirements are met)

EFFECTIVE: Upon Hire

As a Spencer Hospital employee, you are eligible for various discounts noted below.
ELIGIBILITY: All employee classifications (as long as hourly requirements are met)
EFFECTIVE: Upon Hire

Outpatient Discount

Employees may receive a 20% discount on all hospital outpatient charges if they carry health insurance and the bill is paid within 60 days of the invoice date. A 10% discount applies if no health insurance is carried. This discount cannot be combined with any other discount available in Patient Accounts.

Cafeteria Discount

While working you receive a 20% discount on your own meals in the hospital's cafeteria. Payment may be made through payroll deduction or cash. Note: Some items such as vendor-provided soda pop and ice cream treats may be ineligible for this discount.

YMCA Discount

The Spencer Family YMCA offers a membership discount to Spencer Hospital employees.
Various other discounts are offered to our employees.
More information on these discounts can be found on Policy Manager.

Vaccinations

You may receive certain vaccinations, including flu, recommended by the hospital at no cost.

PAID-TIME OFF

Paid time you receive while away from work. You may use this time for vacation, holiday, illness, or personal reasons pending manager approval.

EMPLOYEE ELIGIBILITY: Full-time: 60-80 hours/pay period
Part-time: 40-59 hours/pay period

EFFECTIVE: Starts accruing immediately, available for use after 90 days of employment. Employees may use PTO to supplement holidays within the first 90 days of employment.

Annual PTO accrual (80 hours/pay period)

	Annual Accrual	Maximum Days	
0-4 years	22 days (.084615/hr)	46.50 days (372 hours)	
5-9 years	27 days (.103846/hr)	46.50 days (372 hours)	*Directors start accruing at this level
After 10 years	31 days (.11923/hr)	46.50 days (372 hours)	*President, Vice Presidents, and Providers start accruing at this level

PTO may be carried over from year to year, may be donated to fellow employees, and PTO buy back options are offered twice a year to eligible employees over 150 hours for Full-time and 75 hours for Part-time.

WAGE INCENTIVES

Here at the Spencer Hospital, we recognize the importance of maintaining competitive wages and recognizing career milestones of our employees.

INCENTIVE	ELIGIBILITY	DESCRIPTION
Holiday Pay	All employee classifications	If you are scheduled and work on any one of the seven holidays recognized by the hospital, you will be compensated at 1½ times your regular hourly rate.
Overtime Pay	All employee classifications	You will be paid 1½ times your regular hourly wage for all time worked over 40 hours per week.
Call Pay	All employee classifications	Eligible employees will receive $2.25 per hour for all time spent on call status.
Callback Pay	All employee classifications	Regularly scheduled employees who are granted call-back status by hospital administration and are called to work non-scheduled time will receive 1½ times their regular hourly rate for time worked, plus an additional half hour for travel time.
Double-shift Pay	All employee classifications	Staff members who work an entire double shift, or 4 hours past a 12-hour shift, will be compensated at a rate of 1½ times their regular hourly rate for the second shift.
Shift Differential	All employee classifications	Eligible staff members are paid an additional $1.25 per hour for the 3-11 shift and $1.75 per hour for the 11-7 shift.
Weekend Differential	All employee classifications	Eligible staff members are paid an additional $.85 per hour for all weekend shifts beginning on Saturday or Sunday.
Additional Weekend Pay	All employee classifications	When staff members work an additional weekend shift approved by their managers, they will be paid a premium for working the extra weekend.
Instructor Incentive Pay	All employee classifications	Employees teaching an approved continuing education class are eligible for a $6 per hour differential for both instructor and prep time.
BSN Credit	Staff nurses	Eligible staff nurses will receive a 3% increase to their base wage with verification of a Bachelor of Science in Nursing.

IMPORTANT NOTICE SPENCER 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 Spencer 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. Spencer Hospital has determined that the prescription drug coverage offered by the Health Partners 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.

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 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Spencer Hospital coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Spencer Hospital 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 Spencer Hospital and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Spencer Hospital 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:	1/1/2023
Name of Entity/Sender:	Spencer Hospital
Contact--Position/Office:	Candace Daniels
Address:	1200 First Avenue East, Spencer, IA 51301
Phone Number:	(712) 264-6643

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

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

> Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is 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.

What is the Health Insurance Marketplace?

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

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) 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. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Candace Daniels at (712) 264-6643 or cdaniels@spencerhospital.org.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

NOTICE REGARDING WELLNESS PROGRAM

Spencer Hospital wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary biometric screening, which will include a blood test for cholesterol, triglyceride and glucose levels, as well as measurements of height, weight, waist, and blood pressure. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of reduced medical premiums. Although you are not required to participate in the biometric screening, only employees who do so will receive the wellness incentive.

The information from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as Naturally Slim or wellness coaching. You also are encouraged to share your results or concerns with your own doctor.

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse, doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Candace Daniels at (712) 264-6643 or cdaniels@spencerhospital.org.

PRIVACY NOTICE

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

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
- 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.

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.

Holmes Murphy & Associates has assembled the finest staff of benefits professionals whose expertise is matched by their intelligence and integrity. We further arm them with continuous education, training, and cutting-edge technical resources. These highly specialized consultants have helped us build our reputation for excellence and fuel our growth.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your benefits manager.