

Welcome to the Blessing Health System 2027 Total Rewards Guide

Table of Contents

2027 Total Rewards Guide

ENROLLMENT & ELIGIBILITY

2. Welcome

3. Enrollment Reminders

4. Eligibility

5. Spousal Certification and How to Pick Your Plan

PHYSICAL WELLBEING

6. Medical Coverage Summary

7. Medical Plan Contributions

8-9. Prescription Drug Coverage

10. Navigating the Provider Network

11. Finding a Provider

12. Know Where to Go

13. Dental Plan

14. Vision Plan

15. Reduced Premium Program

16-17. Health Savings Account (HSA)

18-19. Flexible Spending Accounts (FSAs)

20. FSA vs HSA

21. Be Well at Work Wellness Program

22. Diabetes Management Program

23-24. Wellness Center

FINANCIAL WELLBEING

25-26. Supplemental Health Benefits

27. Life and AD&D Insurance

28. Voluntary Life and AD&D Insurance

29. Permanent Life with LTC

30. Disability Insurance

31. Parental Leave

32. Employee Assistance Program (EAP)

33. Legal Plan

34. Pet Insurance

35. Retirement Plan

EMOTIONAL WELLBEING

36. Paid Time Off

RESOURCES & REGULATIONS

37. Carrier Contacts

38. Glossary

39. Important Regulations

THIS DOCUMENT PREPARED FOR THE TEAM MEMBERS OF:

Blessing Hospital • Illini Community Hospital • Blessing Health Hannibal • Denman Services
Blessing-Rieman College of Nursing & Health Sciences • Blessing Foundation • Blessing Corporate Services

Key Features of Your 2027 Benefits

Blessing Health System is pleased to offer a full range of benefits through the following carriers effective January 1, 2027. See details below.

- **Medical/Rx:** We offer three medical plans through Current Health Solutions.
- **Health Savings Account (HSA):** The HSA is a tax-favored account used in conjunction with the high deductible health plan. This account is offered through MyChoice.
- **Supplemental Health Benefits:** We offer Accident, Hospital Indemnity and Critical Illness Insurance through Lincoln Financial Group.
- **Dental:** Delta Dental manages the dental benefit.
- **Vision**: Blessing Health System partners with VSP Vision to manage the vision benefit.
- **Flexible Spending Accounts (FSAs):** You have access to a health care, and/or dependent care FSA. The Health Care FSA is managed by Gray, Hunter, Stenn LLP and the Dependent Care FSA is managed by Blessing's internal Fiscal Services Department. This benefit requires a new election each year to continue participation.
- **Basic Life and AD&D:** Your benefit includes Life and Accidental Death and Dismemberment (AD&D) insurance through Lincoln Financial Group.
- **Voluntary Life Benefits:** You can purchase additional Supplemental Life and AD&D for yourself, spouse and dependent children.
- **Disability:** Lincoln Financial Group manages the short-term and long-term disability benefit.
- **Permanent Life with Long-Term Care:** In the event of an emergency or the unimaginable, The Standard's universal life insurance can help families with financial support to maintain their quality of life.
- **Added Benefits:** You have the option to elect Legal, Identity Theft and Pet Insurance through MetLife.
- **Leaves/FMLA:** Administered by Lincoln Financial Group.

Welcome to Blessing Health System's Benefits Guide

Blessing Health System is pleased to present your enrollment information. We take pride in offering an affordable, quality health care package that helps to protect you and your family's health care needs. This guide provides the information you need to understand your benefit options and complete your enrollment.

Each year, we review our benefits package to ensure it continues to provide value to our employees and their families. We encourage you to review your choices carefully and select the coverage that best supports your needs in the coming year.





Enrolling in Coverage

Blessing Health System shares in the cost of your benefits and offers a range of medical, dental and vision options for you and your family. Your contributions are deducted from your pay before taxes, which may reduce your taxable income. The amount you pay depends on the plans and coverage level you select. You can choose any combination of medical, dental, and/or vision coverage. The only requirement is that as an eligible employee of Blessing Health System, you must elect coverage for yourself in order to elect coverage for dependents. Be sure to have the Social Security numbers and birth dates for any eligible dependents that you plan to enroll. You cannot enroll your dependent(s) without this information.

MAKING YOUR BENEFIT ELECTIONS

Plan for the Year Ahead

Consider expected care, prescriptions, preferred providers and any changes in your household that may affect the coverage you choose for 2027.

Compare Plans and Coverage

Review each plan's coverage, employee cost, provider network, and out-of-pocket costs. Confirm that your dependents and beneficiaries are listed correctly.

Understand the Full Cost

Compare payroll contributions, deductibles, copayments, and other costs you may pay when receiving care. The plan with the lowest payroll contribution may not have the lowest overall cost.

Consider an HSA or FSA

Depending on the plan you select, an HSA or FSA can help you pay eligible health care expenses with contributions deducted before taxes. Review the eligibility requirements and account rules before enrolling.

Complete Your 2027 Enrollment

Access Benefitsolver through Virtual HR or at www.blessinghealth.org/totalrewards. Review your information, make your elections, and submit your enrollment.

ELIGIBILITY

To be eligible for benefits, an employee must work a minimum of 16 hours per week and be in an eligible benefit status. Coverage for most benefits is effective on the 1st of the month after 30 days of employment in a benefit-eligible position. Your benefit elections will remain in effect through December 31 unless you experience a qualifying life event or lose eligibility for benefits. Short-Term Disability and Long-Term Disability are effective the 1st of the month after 180 days in an eligible status.

DEPENDENT ELIGIBILITY

You may enroll your eligible dependents when you enroll yourself. Dependents who are eligible for benefit coverage include:

- Your legal spouse if they do not have access to employer-sponsored medical coverage;
- Your dependent child(ren) up to age 26 whether they are a full time student or not. Coverage ends at the end of the month following the date they turn 26;
- A dependent child age 26 or older who became mentally or physically incapacitated before age 26, is not capable of self-support, and remains dependent on you for support.

QUALIFIED LIFE EVENTS

You may make changes to your benefits during the year if you experience a qualified life event. Qualifying life events must be submitted within **31 days** of the effective date of the event. Some examples of a qualifying life event are:

- Birth or adoption of a child
- Marriage
- Divorce and/or legal separation
- Death or loss of a dependent or spouse (including loss of dependent status)
- Change in your spouse's employment status causing a loss or gain of benefits coverage
- Change in your employment status affecting your benefit eligibility
- Change in residence that affects the benefits offered to you
- Eligibility for Medicare

NEW HIRES

New employees must complete their benefit enrollment within the first 31 days of employment.

If elections are not made within this time frame, the new employee will be defaulted to the company provided benefits.

If you wish to participate in the Blessing Health System benefit plans, enrollment should be completed by logging into BenefitSolver on a Blessing computer, or on a personal computer or handheld device. You may also call the BenefitSolver Service Center at 855-505-7593 to complete your new hire enrollment over the phone. We strongly encourage you to review the plan options available to you to ensure you select the benefit coverage that best meets the needs of you and your covered family members.

TERMINATION OF COVERAGE

Coverage for Health, Dental and Vision terminates on the last day of the month in which employment terminates. Premiums for the remainder of the coverage period will be collected on your final paycheck.

Coverage for Life Insurance, Accidental Death & Dismemberment, and all Supplemental Health Benefits ends effective the date of your termination of employment.

Coverage of Short-Term and Long-Term Disability terminates on the last day of active employment. If termination is a result of a documented disability, coverage will continue until benefits would normally cease.

Any termination due to a qualifying life event will be effective on the date of the life event. Employees will not have coverage through the end of the month.

To report a life event during the year, contact the Benefits Service Center at 855-505-7593 within 31 days of the event.

Spousal Certification and How to Pick Your Plan

Beginning January 1, 2027, spouses who have access to employer-sponsored medical coverage through their own employer will no longer be eligible for medical coverage under the Blessing Health plan. Spouses may continue to be eligible for coverage if they:

- Are self-employed
- Work for an employer that does not offer medical coverage
- Are otherwise not eligible for medical coverage through their employer

Employees currently covering or enrolling a spouse for coverage will be required to certify their spouse's eligibility annually.

HOW TO PICK YOUR MEDICAL PLAN

Blessing Health System offers its employees the ability to choose from two Preferred Provider Organization Plans (PPOs) and one High Deductible Health Plan (HDHP) administered by Current Health Solutions. The medical plans offered by Blessing Health System provide coverage for Essential Health Benefits as defined by the Affordable Care Act. For a full explanation of these coverages, please review the Summary of Benefits and Coverage (SBC) documents found on **Virtual HR.**

Enhanced Health Plan

This medical plan is designed for employees who live outside the Current Health Solutions' service area or who prefer to pay a higher premium in exchange for a higher level of coverage and a greater coinsurance benefit when using Tier 2 providers.

Standard Health Plan

This medical plan is designed for employees who prefer to pay a lower premium while maintaining medical and prescription coverage. This plan offers copays for office visits and prescriptions, along with a lower deductible but a higher out-of-pocket maximum compared to the Enhanced Health Plan.

High Deductible Health Plan (HDHP)

This medical plan is designed for employees who prefer to pay the lower premium contribution for their health care and prescription coverage while having the opportunity to contribute to a Health Savings Account (HSA). Employees will pay more up front for medical services and prescriptions until the deductible is satisfied. Eligibility requirements must be met to contribute to an HSA. See page 16 for more information.

Deductibles & Out-of-Pocket Maximums

Employees enrolled in family coverage will need to satisfy the family deductible before the plan begins to pay. Please note that the maximum out-of-pocket expenses will vary based on the Tier level of services used. Preventive care services are covered at 100% in Tiers 1 and 2.



Current Health Solutions Medical Benefits

The chart below provides a summary of benefits by plan type. The chart highlights basic details including copayment and coinsurance levels for both in and out-of-network providers. Please refer to the Summary of Benefits for more details on these plans.

	Standard Plan			Enhanced Plan			High Deductible Plan		
BLESSING Health System	In-Network		Out-of-Network	In-Network		Out-of-Network	In-Network		Out-of-Network
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
ANNUAL DEDUCTIBLE **All benefits with a coinsurance % are first subject to the respective deductible, unless noted otherwise**									
Annual Deductible: Individual Employee + Children Employee + Spouse Family	 $500 $750 $1,000 $1,000	 $2,000 $3,000 $4,000 $4,000	 $3,000 $5,000 $5,000 $7,000	 $1,000 $2,000 $2,000 $2,000	 $1,250 $2,500 $2,500 $2,500	 $2,500 $5,000 $5,000 $5,000	 $2,000 $4,000 $4,000 $4,000	 $3,500 $7,000 $7,000 $7,000	 $5,000 $10,000 $10,000 $10,000
Out-of-Pocket Maximum: Individual Employee + Children Employee + Spouse Family	 $7,350 $12,300 $14,700 $14,700	 $7,350 $12,300 $14,700 $14,700	 No limit No limit No limit No limit	 $4,000 $5,000 $8,000 $8,000	 $5,000 $7,000 $9,000 $9,000	 No limit No limit No limit No limit	 $4,000 $8,000 $8,000 $8,000	 $7,000 $14,000 $14,000 $14,000	 No limit No limit No limit No limit
PCP Copay	$0	$45	50%	$0	$45	50%	90%	70%	50%
Specialist Copay	$30	$80	50%	$30	$80	50%	90%	70%	50%
Second Opinion	100%	100%	100%	100%	100%	100%	90%	70%	50%
Immediate Care Services	$0	$45	50%	$0	$45	50%	90%	70%	50%
EMERGENCY SERVICES									
Emergent Ambulance (Ground, Air) Non-Emergent Ambulance (Ground, Air)	100% 90%	100% 90%	100% 90%	100% 90%	100% 90%	100% 90%	90% 90%	90% 90%	90% 90%
Emergency Room Copay (waived if admitted)	$300	$300	$300	$300	$300	$300	90%	90%	90%
HOSPITAL /SURGICAL SERVICES									
Inpatient Surgery Outpatient Surgery	90% 90%	70% 70%	50% 50%	90% 90%	80% 80%	50% 50%	90% 90%	70% 70%	50% 50%
Wellness and Preventive Care	100%	100%	Not Covered	100%	100%	Not Covered	100%	100%	Not Covered
Diagnostic Testing (including lab/x-ray)	90%	70%	50%	90%	80%	50%	90%	70%	50%
Outpatient Therapy (60 visits combined max) Physical, Occupational, Speech	$20	70%	50%	$20	80%	50%	90%	70%	50%
Chiropractic Care	$20	70%	50%	$20	80%	50%	90%	70%	50%

Medical Plan Contributions

Each year, Blessing Health System reviews our benefit programs to make revisions and updates and ensure that we continue to offer a competitive, cost-effective benefit program to you and your family. Below is a chart outlining your medical contributions for the 2027 plan year. The chart below shows rates based on bi-weekly payroll deductions.

Level of Coverage	Medical—Full Time			
	Standard Plan		Enhanced Plan	High Deductible Health Plan
	With Wellness Incentive	Without Wellness Incentive		
Employee	$105.56	$142.45	$167.33	$57.55
Employee + Spouse	$231.80	$312.80	$334.66	$125.43
Employee + Child(ren)	$200.05	$269.98	$322.95	$112.02
Family	$278.85	$376.30	$520.39	$152.80

Level of Coverage	Medical—Part Time			
	Standard Plan		Enhanced Plan	High Deductible Health Plan
	With Wellness Incentive	Without Wellness Incentive		
Employee	$211.13	$284.91	$311.64	$78.71
Employee + Spouse	$463.60	$625.63	$651.55	$250.83
Employee + Child(ren)	$400.12	$539.95	$596.43	$224.05
Family	$557.68	$752.60	$901.59	$305.59



Prescription Drug Coverage

When you enroll in a Blessing Health System medical plan, you automatically receive prescription drug coverage through Optum Rx. Our prescription drug program is a formulary-based program. A formulary is a list of carefully selected drugs chosen for their safety, medical effectiveness and cost by Optum Rx. The formulary is reviewed periodically, and medications may be added or removed. This means if you choose a drug on the Premium Formulary listing, you pay either the generic copay, preferred-brand copay, or non-preferred brand copay depending on the drug prescribed. Medications that are excluded on the formulary are not covered by the plan. If you choose to fill one of these medications, you will need to pay the full cost out of pocket. When enrolled in the HDHP medical plan, you must meet the plan's deductible before coinsurance applies. Before starting a new medication, speak with your physician about formulary alternatives that are covered by the plan. You can access the formulary list through Virtual HR or search for covered medications at OptumRx.com.

Our Prescription Drug Benefit divides medication into three tiers:

1. **Generic:** These drugs are the most affordable way for you to obtain quality medications at the lowest cost. A generic drug is labeled with the medication's basic chemical name and usually has a brand-name equivalent. The U.S. Food and Drug Administration (FDA) requires that generic drugs have the same active chemical composition, same potency and be offered in the same form as their brand-name equivalents.
2. **Preferred Brand:** These are brand-name medications that are preferred by the plan based on factors such as safety, effectiveness, and cost.
3. **Non-Preferred Brand:** These are brand-name medications that are covered by the plan but are not on the preferred drug list. They generally have higher out-of-pocket costs than preferred brand medications.

Please note: you are responsible for the lesser of: (1) the applicable copayment or coinsurance required under the Plan, or (2) the pharmacy's charge for the covered prescription drug.

Optum Rx Prescription Drug Coverage				
Tier	Standard Plan		High Deductible Plan	
	Brown Drug Company (Quincy)		Brown Drug Company (Quincy)	
	Denman Country Drugs (Golden), Blessing Health Hannibal	Participating Optum RX Pharmacy	Denman County Drugs (Golden) Blessing Health Hannibal	Participating Optum RX Pharmacy
	Illini Health Services (Pittsfield)		Illini Health Services (Pittsfield)	
Generic (30 Day)	$7 copay or 10% of the cost	$25 copay or 25% of the cost	10% after deductible	20% after deductible
Preferred Brand (30 Day)	Greater of $45 copay or 40% of the cost	Greater of the $60 copay or 55% of the cost	20% after deductible	30% after deductible
Non-Preferred Brand (30 Day)	Greater of $75 copay or 45% of the cost	Greater of $90 copay or 60% of the cost	30% after deductible	40% after deductible
Specialty Medications: may only be filled through Blessing's Specialty Pharmacy or Optum RX Specialty Pharmacy if unavailable through Blessing *Limited to a 30-day supply	10% coinsurance	Not covered	10% after deductible	Not covered

Optum Rx Prescription Drug Coverage		
Tier	Enhanced Plan	
	Brown Drug Company (Quincy)	
	Denman Country Drugs (Golden), Blessing Health Hannibal	Participating Optum RX Pharmacy
	Illini Health Services (Pittsfield)	
Generic (30 Day)	$7 copay or 10% of the cost	$25 copay or 25% of the cost
Preferred Brand (30 Day)	Greater of $45 copay or 40% of the cost	Greater of the $60 copay or 55% of the cost
Non-Preferred Brand (30 Day)	Greater of $75 copay or 45% of the cost	Greater of $90 copay or 60% of the cost
Specialty Medications: may only be filled through Blessing's Specialty Pharmacy or Optum RX Specialty Pharmacy if unavailable through Blessing *Limited to a 30-day supply	10% coinsurance	Not covered



Provider Guide: Navigating the Provider Network

Blessing Health System uses a tiered provider network to help manage healthcare costs while providing employees and their families access to quality care. The amount you pay depends on the provider or facility you choose.

Tier 1 includes Blessing providers and facilities, along with participating providers in the Clinically Integrated Network and Crossriver Quality Health Partners. You will generally pay the least when you receive care from a Tier 1 provider.

The Current Health Network provides additional **Tier 2** options, including access to First Health Network providers across the United States. Tier 2 may be helpful when care is not available within Tier 1 or when you need care while traveling. Services rendered by at Tier 2 provider will be processed in accordance with the plan documents. Employees should expect to have a greater cost share when utilizing a Tier 2 provider.

Blessing Health System	Current Health Solutions
In-Network Tier 1 Blessing Domestic & Crossriver Quality Health Partners	In-Network Tier 2 Current Health Network, First Health Providers (Out of Area Only) and Direct Agreements
Advance Physical Therapy	Barnes Jewish Facilities
Blessing Hospital	Columbia Orthopedics and Surgery Center
Blessing Physician Services	Hannibal Regional Hospital & Medical Group
Davita Adams County Dialysis	Midwest Orthopedics
Denman Services	Quincy Medical Group
Family Eyecare	SIU Family Medicine
Blessing Health Hannibal	Springfield Clinic
Hannibal Anesthesia Associates	Springfield Memorial Hospital
Illini Community Hospital	St. John's Hospital and Additional HSHS Facilities
Northwest Missouri Ambulatory Surgery Center	St. Louis Children's Hospital
Performance Spine and Sports Center	Washington University
Quincy Anesthesia Associates	
Radiology Partners	
Riverside Dermatology & Spa	
SIU Family Medicine (Quincy)	
West Central Pathology Specialists	

Note: This is not the full list of in-network providers. Please check online at **currenthealthsolutions.org** or call Member Services at **855.247.3233** to confirm a provider's network status.

Finding a Provider

Visit **currenthealthsolutions.org/blessing** to find an in-network provider. Click on the BHS Employee Provider Directory tab. From here, you will be able to access searchable provider directories for Tier 1, Tier 2 and First Health providers.

Finding a Tier 1 Provider

Click on the Tier 1 Provider Directory link. This link will take you to the searchable directory. When searching for a provider, enter your zip code to find providers near you. Under Network, it should say Blessing Hospital Tier 1 Provider Directory. Use the drop-down arrows to choose a Provider Type or Specialty. Click Find a Provider.

Finding a Tier 2 Provider

To find a provider in the Tier 2 network, click on the Tier 2 Provider Directory link from the Blessing member page. When searching for a Tier 2 provider, the Network should read “Blessing Hospital Tier 2 Provider Directory”. Use the drop-down arrows to choose a Provider Type or Specialty. Click Find a Provider.

First Health Network

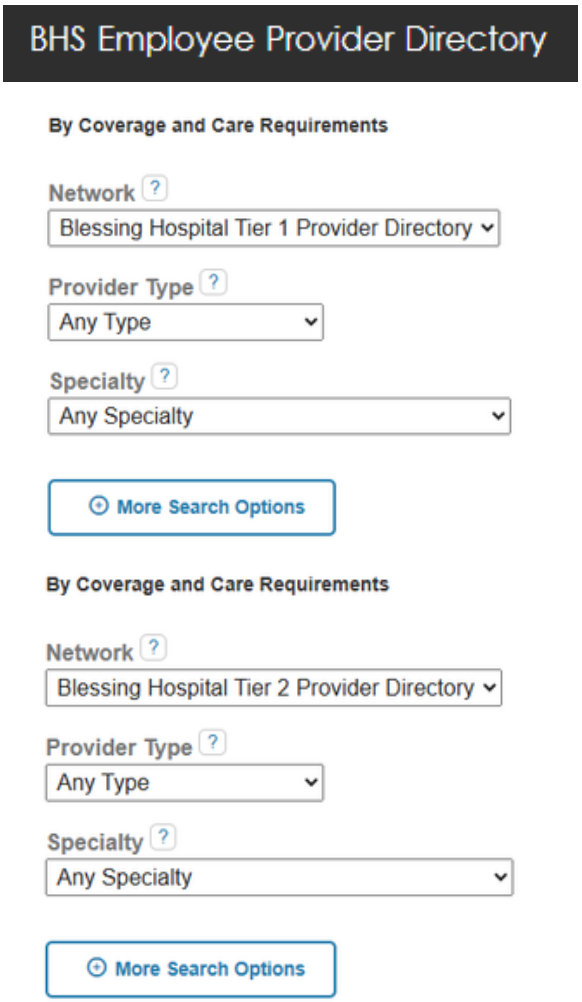
Members may seek services outside of the Current Health Primary Service Network Area at Tier 2 when using the First Health Network.

This map indicates the Current Health Solutions primary service area. When searching for a First Health provider, please ensure they are located outside the highlighted area.

Finding a First Health Provider

To find a First Health Provider, click on the First Health network directory link from the Blessing member page. From here, you will be directed to the First Health website to continue with your provider search.

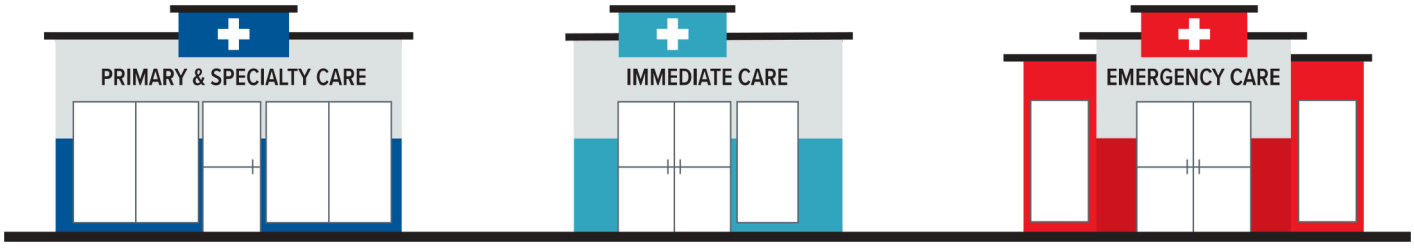






First Health®

Know Where to Go



Your **FIRST STOP** for every day health issues.
Our primary care providers are located throughout the region in Illinois and Missouri, and offer annual wellness exams, convenient appointments and chronic illness management.

Blessing Health continues to build a network of 60+ specialists that travel to our locations across the region and provide excellent care, close to home.

BLESSING HEALTH
927 Broadway, Quincy, IL
4800 Maine, Quincy, IL
326 N. 24th St., Quincy, IL
102 Prairie Mills Rd., Golden, IL
1102 N. County Rd. 700, Warsaw, IL
103 E. Commercial St., Kahoka, MO
521 E. 521 Main, Mt. Sterling, IL
6996 County Rd. 326, Palmyra, MO
400 North Main, Monroe City, MO

BLESSING HEALTH HANNIBAL
100 Medical Dr., Hannibal, MO

ILLINI RURAL HEALTH CLINIC
640 W. Washington, Pittsfield, IL

For **IMMEDIATE**, less serious health concerns when you're unable to get an appointment or after hours.
Treating minor illnesses and injuries:

- Allergies
- Cold, Flu or Fever
- Ear Infection
- Minor Cuts & Lacerations
- Nausea, Vomiting & Diarrhea
- Skin Conditions
- Sore Throat
- Urinary Tract Infection

BLESSING EXPRESS CLINIC
420 N. 34th St., Quincy, IL

BLESSING EMPLOYER CLINIC
326 N. 24th St., Quincy, IL

BLESSING ORTHOPEDIC WALK-IN CLINIC
4800 Maine, Quincy, IL

BLESSING WALK-IN CLINIC
11th & Broadway, Quincy, IL

HANNIBAL WALK-IN CLINIC
100 Medical Dr., Hannibal, MO

ILLINI EXPRESS CLINIC
640 W. Washington, Pittsfield, IL

Go to the **EMERGENCY DEPARTMENT** or call 9-1-1 for serious or life-threatening conditions.
Available 24/7 to handle any emergency and trauma:

- Broken Bones
- Chest Pain
- Loss of Consciousness
- Heart Attack
- Major Trauma or Injury
- Poisoning
- Seizures
- Severe Burns
- Stroke
- Uncontrolled Bleeding

BLESSING HOSPITAL
11th & Broadway, Quincy, IL

ILLINI COMMUNITY HOSPITAL
640 W. Washington, Pittsfield, IL



BLESSING HEALTH PHARMACY
100 Medical Dr., Hannibal, MO

BLESSING HOSPITAL RETAIL PHARMACY
1005 Broadway St., Rm 1970-107, Quincy, IL

BLESSING HEALTH SPECIALTY PHARMACY
1005 Broadway St., Rm 1954-304, Quincy, IL

BROWN DRUG
1121 Maine St., Quincy, IL

BROWN DRUG PALMYRA
1208 S. Main St., Palmyra, MO

BROWN DRUG PITTSFIELD
825 W. Washington, Pittsfield, IL

DENMAN COUNTRY DRUG
102 Prairie Mills Rd., Golden, IL

ILLINI HEALTH SERVICES PHARMACY
321 N. Monroe St., Pittsfield, IL

BLESSING HEALTH

For a complete list of locations, visit
blessinghealth.org/locations

Delta Dental Plan

Blessing offers two dental plan options through Delta Dental: the Value Plan and the Premier Plan. Each plan provides a different level of coverage and access to dental services. The comparison below outlines what each plan covers and how benefits are paid.

Feature/Service	Delta Dental			
	Value Plan		Premier Plan	
	In-Network	Non-Network Dentist	In-Network	Non-Network Dentist
Individual Annual Deductible (applies to Basic care)	$50 *(waived for preventive)*			
Family Annual Deductible (applies to Basic care)	$150 *(waived for preventive)*			
Annual Maximum/Person	$1,300	$1,300	$1,500	$1,500
Preventive and Diagnostic Exams, cleanings, x-rays, sealants	100%	100%	100%	100%
Basic Services Fillings,repair/maintenance of crowns, bridgework and dentures, simple extractions	80%	80%	80%	80%
Major Services Crowns, inlays, onlays and cast restorations, implants, oral surgery, general anesthesia, endodontic services/root canal and periodontic services	Not Covered	Not Covered	50%	50%
Orthodontic Care Adult and Child Orthodontia	Not Covered	Not Covered	50%	50%
Orthodontic Lifetime Maximum	Not Covered	Not Covered	$1,500	$1,500

Level of Coverage	Dental Plan Contributions	
	Value Plan	Premier Plan
Employee	$12.44	$21.00
Employee + Spouse	$24.88	$42.00
Employee + Child(ren)	$34.42	$52.98
Family	$45.31	$73.11

VSP Vision Plan

Blessing Health offers optional vision coverage through the VSP Choice Network for you and your eligible family members. The plan helps cover routine eye exams, glasses, contacts, and other vision services. You will receive the highest level of coverage when you visit a VSP network eye doctor.

Things to Think About...

- How many people in your family will take advantage of vision benefits?
- Do you, or someone in your family, wear glasses or contacts?

Services	VSP	
	Base Plan (In-Network)	Buy Up Plan (In-Network)
Annual Copayment Examination Materials	$5 copay N/A	$5 copay N/A
Examinations Frequency Benefit	Once every calendar year 100% after $5 copay	Once every calendar year 100% after $5 copay
Lenses Frequency Benefit Single Vision Bifocal Vision Trifocal Vision	Once every calendar year $25 $25 $25	Once every calendar year $25 $25 $25
Contacts (in lieu of glasses) Frequency Benefit	Once every calendar year Covered up to $150 for contacts; copay does not apply Contact lens exam (fitting and evaluation) up to $60 copay	Once every calendar year Covered up to $175 for contacts; copay does not apply Contact lens exam (fitting and evaluation) up to $60 copay
Frames Frequency Benefit Feature Frame Brand Allowance Walmart/Costco Equivalent Frame	Every other calendar year Covered up to $160 $180 $90	Every other calendar year Covered up to $175 $195 $95
VSP EasyOptions Every calendar year, members can choose one of these upgrades	Not offered	Fully covered premium or custom progressive lenses, fully covered light-reactive lenses, or fully covered anti-glare coating

Level of Coverage	Vision Plan Contributions	
	Base Plan	Buy-up Plan
Employee	$3.48	$5.81
Employee + 1	$6.94	$11.61
Family	$11.18	$18.70

This table only provides the plan differences at a high level. For a more detailed summary, including out of network benefits, refer to the Benefits Summary for each plan.

Reduced Premium Program



Blessing Health System leadership recognizes the cost of health plan premiums is a financial challenge for some employees.

The Reduced Premium Program is for employees who are enrolled in the Blessing Health System employee health plan and meet the eligibility guidelines. **It offers the opportunity to participate in the Standard Health Plan at a reduced bi-weekly premium.**

Applicants must be:

- In a **full-time** employment status
- Enrolled in the **Standard Health Plan**
- At a household **income level below 275% of the Federal Poverty Level**. This program is based on household size and income levels, NOT who you cover on your health plan.

Documents required to determine eligibility:

- Completed Reduced Premium application
- Copy of your spouse's (or other adult living in the home) 2 most recent pay stubs
- Proof of **all** income benefits that your household receives including pension, retirement, trusts, Social Security, unemployment, rental property, disability, child support, spousal support, and foster care payments

INCOME GUIDELINES AND PREMIUM REDUCTION PERCENTAGES U.S. Department of Health and Human Services Poverty Guidelines (HHSPG) (Effective January 13, 2026)		
	75% reduction	50% reduction
Family Size	**0 - 250% of HHSPG**	**251 - 275% of HHSPG**
1	$39,900	$43,890
2	$54,100	$59,510
3	$68,300	$75,130
4	$82,500	$90,750
5	$96,700	$106,370
6	$110,900	$121,990
7	$125,100	$137,610
8	$139,300	$153,230
each additional	$14,200	$15,620

2027 Reduced Premium Rates			
Coverage Level	**Actual Premium**	**50% Reduced**	**75% Reduced**
Employee Only	$105.56	$52.78	$26.39
Employee + Child(ren)	$200.05	$100.03	$50.01
Employee + Spouse	$231.80	$115.90	$57.95
Family	$278.85	$139.43	$69.71

If a qualifying life event occurs throughout the plan year, employees may apply within 31 days of the event. Call Human Resources at ext. 6842 for details.

If you qualify for the Reduced Premium Program, you are required to re-apply on an annual basis to continue the reduced rates.

Health Savings Account (HSA) and High Deductible Health Plan (HDHP)

Blessing Health System is committed to helping you and your family manage the high costs of health care by providing you with a Health Savings Account (HSA) that you can use in conjunction with the High Deductible Health Plan (HDHP). An HSA provides tax-free dollars for qualified out-of-pocket health expenses if you are enrolled in a high deductible health plan. The following are a few important things you should know about the HSA/HDHP.

What is a Health Savings Account?

An HSA is a tax-favored account used in conjunction with a HDHP. The HSA allows you to contribute funds on a pre-tax or tax-deductible basis, which you may use to pay for eligible medical, dental and vision expenses. Please note that Blessing Health System does not collect taxable deductions. Eligible expenses are defined by the IRS Publication 502. If you don't use all the money in your account, the balance rolls over to the next year. Those dollars continue to earn interest—and continue to be available for medical expenses year after year.

Who is eligible to establish an HSA?

You are eligible to open an HSA provided you meet the following criteria:

- Must be enrolled in an HDHP
- Must not be covered by another health plan that is not an HDHP
- Not listed as a dependent on another person's tax return
- Not enrolled in benefits under Medicare

The Affordable Care Act (ACA) requires medical plans to cover dependents to the age of 26 (if offered by your employer), but it doesn't require these dependents to be tax dependents. To use HSA funds for dependent expenses, the dependent must specifically be able to be claimed as a dependent on your tax return.

How is a HDHP different than a traditional health plan?

An HDHP generally has lower premiums but a higher deductible than a traditional health plan. Employees pay more upfront for medical services until the deductible is met. Certain preventive services are covered at 100% before the deductible. Once the deductible is met, the plan begins sharing the cost of covered services.

How can an HSA save me money?

An HSA allows you to set aside money on a pre-tax basis to pay for eligible medical, dental, and vision expenses. Unused funds roll over from year to year and may earn interest or investment returns. Funds used for eligible health care expenses are tax-free.

Can I still go to my regular doctor?

Yes. You may continue seeing your regular doctor. However, your out-of-pocket costs will depend on the medical plan tier that your provider participates in.

How does it work?

Since an HSA is a tax benefit, you will need to be able to prove that money you spend from your HSA is for eligible medical expenses. Submit your receipts for eligible expenses to MyChoice to reimburse yourself using your HSA funds. Remember to attach original receipts and any benefits statements along with your claim forms. You can also use your HSA card to pay for eligible expenses.

Health Savings Account (HSA) and High Deductible Health Plan (HDHP)

Do I need to choose a primary care physician and obtain a referral to see a specialist?

No. You have the freedom to use any doctor or hospital without being required to choose a primary care physician or receive referrals.

How much can I contribute to my HSA?

You can contribute up to the maximum contribution limit of $4,500 into an HSA if enrolled in an HDHP with individual (employee-only) coverage or up to $9,000 into an HSA if enrolled in an HDHP with dependents (spouse or children). This maximum contribution includes the Blessing Health System contribution.

If you are married and your spouse has a family HDHP, then both spouses are determined to have family coverage. This is true even if one spouse has a family plan and the other has a self-only plan. Each spouse may have an HSA, and together you may contribute up to the family limit. You may not each contribute up to the family limit.

If you are age 55 or older, you may contribute an additional $1,000 annually to your HSA. This catch-up contribution can be made each year you remain eligible for an HDHP. However, the IRS does not allow HSA contributions for individuals enrolled in Medicare, so HSA contributions must stop once you enroll. You may continue to use your existing HSA funds after enrolling in Medicare, but you cannot contribute additional funds without potentially incurring penalties.

Is the HSA account portable?

Yes. You keep your HSA even if you change jobs, change medical coverage, retire or make other life changes.

How can Health Care Reform impact my HSA and my taxes?

Your HDHP with Blessing Health System allows you to provide coverage for your eligible dependents until they reach age 26. But, the IRS tax law did not change the definition of a dependent for HSA. A tax-dependent is defined as up to age 19 or, if a full-time student, age 24. There can be instances where you can have an adult dependent child covered under your health plan as allowed under the Affordable Care Act (less than age 26), BUT they are not a dependent for tax purposes. If you use the pretax dollars from your HSA to pay for health expenses for your covered dependent (who is not a dependent for tax purposes), you'll pay a penalty plus taxes.

Your covered adult dependent child may open his or her own Health Savings Account and contribute up to the allowed family maximum ($9,000 in 2027), provided they meet IRS eligibility requirements. Please be aware that the deposits to the account will be on a post-tax basis and are not handled through any payroll deductions. You may also continue to save up to the maximum family contribution amount in your own HSA ($9,000 in 2027; if 55 or older an additional $1,000). Reach out to a qualified tax accountant to ensure compliance with the IRS tax law.

Does my employer contribute to the HSA?

Blessing Health System will contribute up to **$500** annually for employee-only coverage and **$1,000** annually for family coverage. The amount received will depend on when you enroll in the HSA and whether you are actively employed when contributions are made. Your elected payroll contributions will be withheld pre-tax each pay period and deposited into the HSA. This means that you will not have access to the full annual contribution at the beginning of the year–it will accrue over the course of the year.

Note: If you enroll in the HDHP and contribute to a Health Savings Account, you cannot enroll in a Health Care Flexible Spending Account (HCFSA). However, you may enroll in a Limited Purpose FSA for eligible dental and vision expenses.

Flexible Spending Accounts (FSAs)

Gray, Hunter, Stenn LLP manages the Health Care Flexible Spending Accounts and Blessing's internal Fiscal Services Department administers the Dependent Care Flexible Spending Accounts. Flexible Spending Accounts (FSAs) are an easy and convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of your pretax dollars to cover certain out-of-pocket expenses as they occur throughout the plan year. Three types of accounts are available—a Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account and a Dependent Care Flexible Spending Account.

HEALTH CARE FSA

A Health Care FSA is a special account you put money into that you use to pay for eligible out-of-pocket medical, dental and vision expenses. With this account, you utilize pre-tax dollars to pay for these eligible expenses, lowering your taxable income from your paycheck.

For 2027, the maximum annual contribution is $3,500.

- **Some examples of eligible expenses include**: copays for provider visits and covered prescriptions, your deductible and coinsurance, eyeglasses and contact lenses, eligible over-the-counter (OTC) items (contact lens solution, band-aids, birth control, etc.), orthodontia and more.
- **Some ineligible expenses**: premiums for medical, dental, vision, etc., amounts reimbursed by health care plans, cosmetic surgery and more. For a complete list of items, visit the Internal Revenue Service (IRS) website at **www.irs.gov**.

LIMITED PURPOSE FSA

If you enroll in the HDHP with HSA plan, you are not eligible to enroll in or deposit money into a health care FSA. You may, however, be able to contribute to a limited-purpose FSA. The limited purpose FSA can be used to pay for dental and vision expenses that you may incur. The "use it or lose it" rule also applies to the limited purpose FSA, so you should estimate your expenses carefully before electing how much to save in this account.

DEPENDENT CARE FSA

The Dependent Care FSA lets you use pretax dollars toward qualified dependent care. **You can contribute up to $7,500 ($3,750 if married and filing separately) in your DCFSA** for children under age 13 and for disabled adults in your care.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of child or adult dependent day care (in or out of your home)
- Nursery schools and preschools (excluding kindergarten) and summer day camp

To use funds for dependent expenses, the dependent must specifically be able to be claimed as a dependent on the employees' tax return. Refer to **IRS Publication 503, Child and Dependent Care Expenses** for more information on who qualifies as a disabled adult.

Flexible Spending Accounts (FSAs) - Continued

KEY FSA PROVISIONS

Use it or Lose it

Estimate your expenses carefully when choosing your FSA contribution amount. The Internal Revenue Service (IRS) has a "use it or lose it" rule for these accounts, which means if you don't spend everything in your FSA by the end of the grace period, you'll forfeit whatever funds remain.

Grace Period & Claim Deadline

Blessing Health System provides a grace period for the Healthcare FSA. You may use remaining 2027 funds for eligible expenses incurred through March 15th, 2028. You have until May 31st, 2028 to submit claims for eligible expenses incurred in 2027 or the grace period. Any remaining funds will be forfeited after the claims submission deadline.

Example: If you have $200 remaining in your HCFSA on 12/31/2027, you may use it for eligible expenses incurred through 3/15/2028. You must submit claims by May 31st, 2028.

For the Dependent Care FSA, you may use 2027 funds for eligible expenses incurred through December 31st, 2027. You have until March 31st, 2028 to submit claims for eligible expenses incurred in 2027; otherwise, any remaining funds will be forfeited after the claims submission deadline.

Important Dates for FSAs

Account Type	Plan Year End	Deadline to Incur Claims	Deadline to Submit Claims
Health Care FSA	12/31/2027	3/15/2028	5/31/2028
Dependent Care FSA	12/31/2027	12/31/2027	3/31/2028



FSA vs. HSA

	Flexible Spending Accounts	Health Savings Accounts
 OWNERSHIP	Your Health Care FSA is provided through Blessing Health System. Your full annual election is availabe at the beginning of the plan year. Your coverage ends on your last day of employment.	An HSA is a savings account in your name, and you always have access to the funds, even if you change jobs.
 ELIGIBILITY & ENROLLMENT	A Health Care FSA may be elected even if you waive other coverage. You cannot increase your contribution during the Plan Year without a Qualifying Life Event, and decreases to your contribution amount are not permitted at any time during the plan year. Enrollment in both a Limited Purpose FSA and an HSA are allowed.	To contribute to an HSA, you must be enrolled in a qualified HDHP and meet IRS eligibility rules. You cannot be covered by another non-HDHP medical plan, Medicare, Tricare, or general purpose Health Care FSA, including one through your spouse. Employees are responsible for confirming eligibility to contribute. For more complete eligibility rules, visit IRS.gov.
 TAXATION	FSA contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	HSA contributions are generally tax-deductible or made pre-tax; the account grows tax-free; and funds are tax-free when used for qualified expenses.
 CONTRIBUTIONS	You can contribute up to $3,500 in 2027 to an FSA. This amount may be increased annually.	Both you and your employer can contribute up to a combined total of $4,500 in 2027 (up to $9,000 for families). Ages 55+ can make an annual $1,000 “catch-up” HSA.
 PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	HSA funds can be used with a debit card provided by MyChoice. Alternatively, you can save funds for future expenses or retirement.
 ROLLOVER OR GRACE PERIOD	Unused FSA funds may be used for eligible expenses incurred through March 15, 2028. Claims must be submitted by May 31, 2028. Any remaining funds will be forfeited.	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
 QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
 OTHER TYPES	Other types include the Dependent Care FSA and Limited Purpose FSA.	N/A

Be Well at Work Employee Wellness Program

Insurance Discount:

Every employee who is on the Standard Wellness Insurance Plan can complete the simple steps to receive a discount on their monthly insurance premium.

To qualify for the discount on the Standard Wellness Insurance Plan, you will need to complete the following two steps:

- Sign the 2027 Required Program Consent which is located on the BRAIN.
- Complete your Annual Wellness Screening with your Primary Care Provider OR onsite with one of our Wellness Coaches before June 30th.

WELCOME TO THE BE WELL AT WORK WELLNESS PROGRAM

Take advantage of all the benefits the program offers

WELLNESS BENEFITS

Wellness Center:

Memberships are available to all new employees for a one-time fee of $25. Take advantage of state-of-the-art cardio equipment, weights, and track. Other Wellness Center offerings include personal training, dietitian consultations, exercise classes, and cooking classes. Please contact the Wellness Center to get signed up today at **217.214.5858** (cost may apply to classes).

Coaching:

Are you trying to reach a goal and need some motivation? Wellness Coaches are available for you all year long. Virtual or in-person. Contact Employee Wellbeing at **employeewellbeing@blessinghealth.org.**

Communication:

The Wellness Team post monthly newsletters that provide wellness tips and lifestyle updates. Participate in the quarterly wellness challenges and presentations.
https://brain.blessinghealthsystem.org/resources/bwaw-employee-wellness.

Portal:

ManageWell offers employees additional tools and resources for your wellness journey. Podcasts, Articles, and Videos on Exercise, Nutrition, Stress, Sleep, Tobacco, and Healthy Aging are all available through the portal along with many other activities. To get registered, contact Employee Wellbeing at **employeewellbeing@blessinghealth.org**.

Be Well at Work Wellness

Scan the QR code for Wellness Coaching

If you have any questions, please reach out to the Employee Wellness Team via email **employeewellbeing@blessinghealth.org** or call **217.223.8400, etx. 2326**.

Diabetes Management Program



Be Well with Diabetes is an employer-sponsored program that provides additional support to employees and family members managing diabetes. Participants have access to providers who specialize in diabetes care, as well as education, coaching and group support from nurses, pharmacists, dietitians, and certified diabetes care and education specialists.

Eligibility Requirements

1. Diagnosis of Type 1 diabetes, Type 2 diabetes, pre-diabetes, or gestational diabetes
2. Blessing Employee Healthcare Plan member

Participant Incentives

In order to qualify for the below incentives, services must be rendered at the Blessing Diabetes Center and Blessing Outpatient Lab. Prescriptions must be filled at a Blessing owned pharmacy. See page 12 for a complete list of locations.

***In compliance with IRS first-dollar coverage limitations, HDHP members are not eligible for all incentives at 100% coverage.**

	Standard Plan	High Deductible Plan	Enhanced Plan
Diabetic Medications *excluding GLP-1 medications*	100%	100%	100%
Diabetic Meters	100%	100%	100%
Continuous Glucose Monitoring	100%	Subject to Deductible	100%
Syringes & Testing Supplies	100%	Subject to Deductible	100%
Blood Hemoglobin A1C	100%, quarterly	100%, twice annually	100%, quarterly
Microalbumin	100%, once annually	Subject to Deductible	100%, once annually
Diabetes Education Classes	100%, unlimited visits	Subject to Deductible, unlimited visits	100%, unlimited visits
Diabetes Coaching	100%, unlimited visits	Subject to Deductible, unlimited visits	100%, unlimited visits
Weight Checks	100%, unlimited visits	100%, unlimited visits	100%, unlimited visits

To enroll in the Be Well with Diabetes Program or join the mailing list, contact the Diabetes Center at 217.214.5814 or 217.223.8400, extension 5900.

A $25.00 per pay period membership fee will be charged to each employee and/or dependent, who is enrolled in the Be Well with Diabetes Program.

PERSONAL TRAINING

Get customized recommendations and expert attention that will help you stay motivated and achieve your goals. Our Personal Trainers are nationally certified and have special areas of expertise.

YOUTH TRAINING PROGRAM.....$75

Children of Wellness Center members ages 11-15 are eligible to enroll in our Youth Training Program. All eligible children are required to complete a series of 5, 30 minute training sessions with one of our Wellness Center trainers. Upon successful completion of the program, the child will be eligible to begin utilizing the facility with a parent/legal guardian at all times.

NUTRITION SERVICES

Meals-To-Go

Our fully-prepared meals are healthy, convenient, reasonably priced and ready to eat. New meals available each week. Place your order and we do all the work.

Nutrition Counseling

Our dietitian can help create a personal plan to meet your goals, answer your questions, and provide education, culinary tips, healthy recipes as well as advice on what to look for in the grocery store.

NUTRITION PACKAGES

Initial Consult Package: 1 (60min) session + 4 (30 min) sessions $140

Customized Meal Plan Package: 1 Meal Plan + 1 (30 min) session $75

On-Going Dietitian Support: 8 (30 min) sessions $180

MEMBERSHIP BENEFITS

FREE 30 Minute Personal Training Session
Complimentary Orientation Session
14,000 sq ft, State-of-the-Art Facility
Cardio & Strength Equipment Access to our Services

MEMBERSHIP TYPES

Blessing Employee Member
Be Well at Work Member
Blessing Volunteer
Student Member
Blessing Family Member
Blessing Retiree Member
Blessing Patient Referral Member

One-time $25 joiner fee upon registration

PERSONAL TRAINING

	30 min session	45min session	60 min session
4 Session Package	$80	$120	$160
8 Session Package	$140	$220	$280
12 Session Package	$180	$300	$360

GROUP EXERCISE CLASSES

10 Class Package (Senior rate)	$50
10 Class Package	$80
25 Class Package	$150

Prospective members should call the Wellness Center at **217.214.5858** to verify eligibility and schedule a new member registration appointment.

4917 Oak St.
Quincy, IL 62305

YOUTH TRAINING PROGRAM

60 MINUTE SESSION PACKAGE.....$20

Children of Illini Fitness members ages 11-15 are now eligible to enroll in the Youth Training Program. All eligible children will be required to complete one, 60 minute training session.

- Child is required to be added to parent/legal guardian membership
- Youth Training Program fee of $20/child paid at time of membership registration
- Membership Registration and Training Session scheduled by appointment only
- Upon successful completion of the program, the child will be eligible to begin utilizing the facility with a parent/legal guardian present at all times

MEMBERSHIP BENEFITS

FREE 30 Minute Personal Training Session
Complimentary Orientation Session Cardio & Strength Equipment

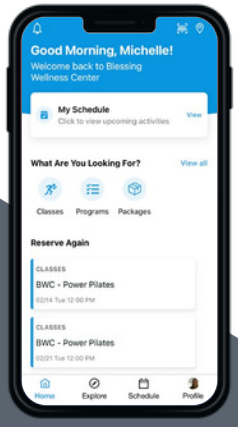
MEMBERSHIP TYPES

Blessing Employee Member
Be Well at Work Member
Blessing Volunteer
Student Member
Blessing Family Member
Blessing Retiree Member
Blessing Patient Referral Member

BLESSING WELLNESS CENTER MOBILE APP

MOBILE APP BENEFITS

View statements & check-in history, update debit/credit card information, or use your individual barcode to access the facility



AVAILABLE NOW!

Download on the App Store

GET IT ON Google Play

321 W. Washington St.
Pittsfield, IL 62363



Prospective members should call Illini Fitness at **217.285.5635** to verify eligibility and schedule a new member registration appointment.

Blessing Health System offers voluntary supplemental health insurance through Lincoln Financial Group. Accident, Hospital Indemnity, and Critical Illness Insurance pay cash benefits directly to you following a covered accident, hospital stay, or critical illness. Benefits are paid separately from your medical plan and may be used for medical costs, travel, everyday expenses or lost income. These plans do not replace medical insurance.

ACCIDENT INSURANCE

Accident Insurance provides benefits for covered injuries and related treatment including ambulance transportation, emergency room care, surgery, stitches, etc. Benefit amounts vary based on the injury and treatment received.

Accident Insurance includes a Child Sports Injury Benefit. This means you will receive an additional benefit of 25%, up to $1,000 for an accident as a result of a sports injury. Enrollees who complete an annual health screening are eligible to receive a wellness benefit. The wellness benefit is $100 per health screening, limited to one eligible screening per covered person per year.

Biweekly Accident Insurance Rates			
Employee	**Employee + Children**	**Employee + Spouse**	**Employee + Family**
$3.60	$7.42	$7.71	$11.52

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity Insurance pays cash benefits when you or a covered family members are admitted to the hospital for a covered stay. Please refer to the below chart for details on how the plan pays:

Hospital Indemnity Benefits	
Core Benefits	**Daily Benefit**
Hospital Admission For the initial day of admission to a hospital for treatment of a sickness/injury	$1,500 per day for one day per calendar year
Hospital Confinement For each day of confinement in a hospital as a result of a sickness/injury	$100 per day for 15 days starting on 2nd day of confinement
Hospital ICU Admission For the initial day of admission to an ICU for treatment as the result of a sickness/an injury	$1,500 per day for one day per calendar year
Hospital ICU Confinement For each full or partial day of confinement in an ICU as a result of a sickness/an injury	$200 per day for 15 days starting the 2nd day of confinement
Complications of pregnancy	Included

Hospital Indemnity Benefits (Continued)	
Additional Confinement Benefits	
Rehabilitation Facility For each day of inpatient confinement to a rehabilitation facility as a result of a sickness/an injury	$50 per day for 15 days per calendar year
Enhanced Benefits	
Hospital NICU Admission Increases the hospital ICU admission benefit for a newborn child's ICU or NICU admission by the percentage shown in the schedule of benefits	25%
Hospital NICU Confinement Increases the hospital ICU confinement benefit for a newborn child's ICU or NICU confinement by the percentage shown in the schedule of benefits	25%

Biweekly Hospital Indemnity Rates			
Employee	Employee + Children	Employee + Spouse	Employee + Family
$7.87	$9.09	$12.83	$17.38

CRITICAL ILLNESS INSURANCE

Critical Illness insurance pays benefits for specific covered medical conditions and diagnoses such as heart attack, cancer, stroke, coronary artery bypass and kidney failure. This coverage is available to you, your spouse and dependent children up to age 26.

Critical Illness rates vary by employee age and coverage amount. Enrollees who complete an annual health screening are eligible to receive a wellness benefit. The wellness benefit is $50 per health assessment (6 per family and a $300 limit). The benefit is limited to one eligible screening per covered person per year.

	Coverage Amount
For you	$10,000, $20,000 or $30,000
Your spouse	Up to 50% of the employee's benefit
Your children, up to age 26	Up to 50% of the employee's benefit



Basic Life and Accidental Death & Dismemberment Insurance

Blessing Health System automatically provides eligible employees with Basic Life and Accidental Death and dismemberment (AD&D) insurance through Lincoln Financial group at no cost. Life insurance provides financial support to your beneficiaries if you die. AD&D provides additional benefits for a covered accidental death or serious injury.

Your Basic Life and AD&D coverage is equal to one times your basic annual salary, excluding overtime and bonuses, up to $750,000. The combined maximum for Basic and Voluntary Life coverage is $1.5 million.

Coverage reduces beginning at age 65. The percentage shown below is the amount of coverage that remains:
Ages 65-69: to 65%
Ages 70-74: to 45%
Ages 75-79: to 30%
Age 80 and older: to 20%

Imputed Income: The IRS considers the value of employer-provided life insurance over $50,000 to be taxable income. The taxable value is calculated using an IRS rate based on your age and the amount of coverage over $50,000. This amount will appear on your paycheck stub and Form W-2 as Group-Term Life Insurance. You are not taxed on the full amount of your life insurance coverage.



Voluntary Life and AD&D Insurance

You may purchase Voluntary Life and AD&D insurance in addition to the Basic Life and AD&D coverage provided by Blessing Health System. Coverage is available for you, your spouse, and eligible dependent children through age 25. To elect coverage for your spouse or children, you must elect Voluntary Life coverage equal to at least one times your basic annual salary.

Evidence of Insurability (EOI) is required if you elect coverage above the guaranteed issue amount or increase your existing coverage by more than one salary multiple - even if the total remains below the guaranteed-issue amount.

**For the Guarantee Issue - Evidence of Insurability is required if you elect coverage above $400,000. If the additional coverage is not approved, your Voluntary Life coverage will default to one times your basic annual salary.

<table>
<tr><th></th><th>Employee</th><th colspan="2">Spouse Life</th><th colspan="2">Dependent Children</th></tr>
<tr><td rowspan="7">Life Amounts</td><td rowspan="7">1x to 4x base annual earnings to a combined maximum of $1,500,000 when combined with basic life.
The cost of employee Voluntary Life coverage is based on the coverage amount you elect and your age as of January 1, 2027. Your cost will be shown during enrollment.</td><td>Coverage</td><td>Rate</td><td>Coverage</td><td>Rate</td></tr>
<tr><td>$10,000</td><td>$0.92</td><td rowspan="5">$10,000</td><td rowspan="5">$0.54</td></tr>
<tr><td>$25,000</td><td>$2.31</td></tr>
<tr><td>$50,000</td><td>$4.62</td></tr>
<tr><td>$75,000</td><td>$6.92</td></tr>
<tr><td>$100,000</td><td>$9.23</td></tr>
<tr><td>Guarantee Issue</td><td>$400,000
Amounts that require evidence of insurability will remain pending until approved by Lincoln.</td><td colspan="2">$50,000</td><td colspan="2">$10,000</td></tr>
<tr><td rowspan="6">AD&D Amounts Single and family coverage available for each</td><td>Coverage</td><td colspan="2">Employee-Only Rate</td><td colspan="2">Family Rate</td></tr>
<tr><td>$25,000</td><td colspan="2">$0.21</td><td colspan="2">$0.32</td></tr>
<tr><td>$50,000</td><td colspan="2">$0.42</td><td colspan="2">$0.65</td></tr>
<tr><td>$100,000</td><td colspan="2">$0.83</td><td colspan="2">$1.29</td></tr>
<tr><td>$150,000</td><td colspan="2">$1.25</td><td colspan="2">$1.94</td></tr>
<tr><td>$250,000</td><td colspan="2">$2.08</td><td colspan="2">$3.23</td></tr>
<tr><td>Age Reduction Schedule (amount of coverage that remains)</td><td>Ages 65-69: to 65%
Ages 70-74: to 45%
Ages 75-79: to 30%
Age 80 and older: to 20%</td><td colspan="2">Ages 65-69: to 65%
Ages 70-74: to 40%
Age 75 and older: to 25%</td><td colspan="2">N/A</td></tr>
</table>

*Rates in the above chart are shown per pay period

Permanent Life Insurance with Long-Term Care

In the event of an emergency or the unimaginable, The Standard's universal life insurance can help families with financial support to maintain their quality of life. A death benefit helps safeguard a family's future after the insured is gone. Plus, the cash value can be borrowed against if there is an emergency in the insured's lifetime.

Highlights

- No physicals or blood work
- Accumulates cash value
- Guaranteed 3% interest rate
- Loan and withdrawal options
- Payroll deduction is not available for this benefit; ACH payments must be set up directly with The Standard

Plan Design

Included Riders:

- Accelerated Death Benefit for Terminal Condition Rider (Rider Form Series CRLTI100)
- Waiver of Monthly Deductions for Layoff or Strike Rider (Rider Form Series CRLWL100)

Optional Additional Riders:

- Accelerated Death Benefit for Chronic Condition Rider (Rider Form Series CRLLT300) Accelerates 4% for monthly benefit or 20% of the death benefit amount as a one-time lump sum payment
- Extension of Benefits Rider (Rider Form Series CRLEX100) Accelerates 4% for monthly benefit

Employee Optional Rider

- Child Term Insurance Rider (Rider Form Series CRLCH100) Benefit of $10,000 or $20,000

Eligibility

Employee: To be eligible for insurance, an employee must satisfy all of the following requirements:

- Be age 16 through 80
- Be on active service, performing in the usual manner all of the regular duties of his or her occupation at one of the places of business where he or she normally works or at some location directed by the employer
- Be continuously employed for the amount of time and working the minimum number of hours per week as you require to be eligible for benefits. These requirements will be defined on the Life and Health Group Application and Agreement.
- Not eligible to be claimed as a dependent on another person's tax return

Spouse: To be eligible for insurance, a spouse (or equivalent as defined by state law or otherwise agreed upon between you and us) must satisfy all of the following requirements:

- Must be age 16 through 65
- Must be legally married to the employee as determined by the laws of the state in which the employee resides or meet the eligibility requirements required by the group to be benefit eligible
- Must not be disabled
- Must not be eligible as an employee under the group policy

Child UL: To be eligible for universal life insurance, a child must satisfy all of the following requirements:

- Must be under the age of 26
- Must be an employee's natural child or child for whom adoption proceedings have begun, or a child for whom the employee has been appointed legal guardian
- Must not be disabled
- Must not be eligible as an employee under the group policy

Child Term Insurance Rider: To be eligible for insurance under this rider, a child must satisfy all of the following requirements:

- Must be 15 days old and no older than age 25
- Must be an employee's natural child or stepchild, legally adopted child or child for whom adoption proceedings have begun, or a child for whom the employee has been appointed legal guardian
- Must not be eligible as an employee under the group policy

Short-Term and Long-Term Disability Insurance

When an illness or injury keeps you from working, a loss of income can add stress to an already difficult time. Blessing Health System provides short-term and long-term disability insurance through Lincoln Financial Group to help replace a portion of your income during an eligible disability. Basic STD and LTD coverage are provided at no cost to eligible employees.

SHORT-TERM DISABILITY (STD) INSURANCE

Employees working at least 16 hours per week and in an eligible benefit status are eligible for STD coverage. STD provides partial income replacement when an eligible illness or injury keeps you from working.

Blessing provides a benefit equal to 60% of your covered weekly earnings, up to $4,000 per week. Benefits begin after a 14-day elimination period and may continue for a maximum of 24 weeks.

You may purchase a buy-up option that increases your total coverage to 75% or 100% of covered earnings. You pay the full cost of the buy-up coverage, which is fully insured through Lincoln Financial Group. While you are receiving approved STD benefits, Blessing pays the company-provided portion every two weeks according to scheduled pay dates, while Lincoln issues a separate weekly check for the buy-up portion. Because buy-up premiums are deducted after taxes, the buy-up benefit paid by Lincoln is not taxable.

Benefit	Coverage Amount
Company-Provided	60% of Covered Earnings
Buy-up Plan	Options of 75% or 100% of Covered Earnings
Elimination Period	14 days
Maximum Weekly Benefit	$4,000

LONG-TERM DISABILITY (LTD)

Employees working at least 32 hours per week and in an eligible benefit status are eligible for LTD coverage. LTD provides partial income replacement when an eligible illness or injury prevents you from working for an extended period.

Blessing provides LTD coverage at no cost to eligible employees. Benefits begin after you have been disabled for 180 consecutive days. The benefit is equal to 50% of your covered monthly earnings up to a maximum monthly benefit of $10,000.

Approved LTD benefits are paid directly by Lincoln Financial Group to eligible employees.

Benefit	Coverage Amount
Company-Provided	50% of Covered Earnings
Elimination Period	180 days
Maximum Monthly Benefit	$10,000

Important Note: Buy-up STD and LTD benefits will not be paid for any period of disability that begins within 12 months of your benefit effective date if that disability is associated with a pre-existing condition. A pre-existing condition is defined as an injury or illness for which you received treatment, diagnostic care or used prescription drugs or medicines within three months prior to the most recent effective date of insurance coverage.

Parental Leave

A growing family brings a lot of questions. Here's what you need to know about parental leave at Blessing:

Blessing Health System (BHS) provides paid time away from work for benefit eligible employees who have recently expanded their family through childbirth, adoption, foster care, or legal guardianship. This time is intended to provide parents or legal guardians time to bond with an addition to their family.



A parent/legal guardian may take up to two weeks (consistent with their employment status) of paid leave due to the birth or placement of a child, under the age of 18, in the employee's home by means of foster care, adoption or legal guardianship. Parental leave will run concurrently with approved family and medical leave under the Family and Medical Leave Act (FMLA). This benefit is allowed no more than once per rolling twelve-month period.

Compensation for parental leave is calculated based on the employee's straight time hourly earnings plus shift differential (if the employee's time off is from scheduled hours for which shift differential would have been awarded). Hours paid under this policy are not considered "hours worked" for the purpose of calculating overtime eligibility, gainshare hours, and accrual of PTO.

Benefit eligible employees will receive up to 2 weeks of paid parental leave. This leave will be used to satisfy the 2-week STD waiting period for birth parents. Non-birth parents may use parental leave within 12 weeks of birth, adoption, or placement of a child.

FMLA

FMLA provides employees with up to 12 weeks of unpaid, job-protected leave in a rolling 12-month period. Employees who have at least one year of service and have worked at least 1,250 hours within the past 12 months, are eligible for FMLA to coincide with their maternity leave.

The Short Term Disability (STD) plan may provide benefits if you are unable to work due to pregnancy, childbirth, and recovery. A physician must certify your leave, which is typically 6 weeks for a vaginal delivery or 8 weeks for a c-section.

Generally, the duration of the STD claim for recovery from childbirth depends on the type of delivery vaginal or c-section. Contact Lincoln Financial Group at 888.605.1129 to report your claim for STD and FMLA. Employees who wish to extend leave beyond the STD benefit may do so by using PTO.
Breast pumps are covered at 100% by Current Health Solutions, the employee healthcare plan.

Employee Assistance Program (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc will be there to help. The SupportLinc Employee Assistance Program (EAP) is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. With the EAP, you get a combined EIGHT sessions and **NO** copay for you and your eligible dependents.

Connect to care your way

- Reach a licensed clinician by phone 24/7/365 when you call for in-the-moment support
- Access no-cost short-term counseling in person or by video for concerns such as stress, anxiety, depression, burnout, or substance use
- Message a Coach to boost your emotional fitness, learn healthy habits, increase resilience, and more

Simplify your everyday life with work-life benefits

- Get expert consultations for financial and legal concerns
- Receive referrals for needs such as child or elder care, pet care, home improvement, or auto repair.

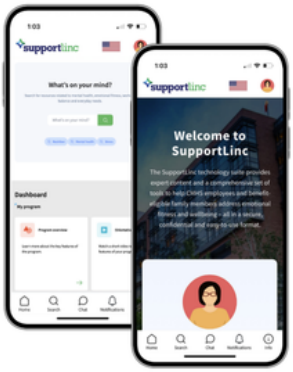
Access Guided Paths

Follow step-by-step programs on topics such as easing anxiety, building resilience, and more with support at every stage of your mental health journey.

Digital access - www.supportlinc.com

The web platform and mobile app make it easy to connect to care and strengthen your wellbeing - anytime, anywhere.

- Create a personalized profile for resources tailored to your needs
- Understand your emotions and receive help with mental health check-ins
- Schedule sessions with a licensed clinician via in-person, video, or text
- Attend anonymous group sessions for support and connection in a safe, text-based space
- Track your mood and journal to build self-awareness and notice progress



Support for everyday issues. Every day.

Download the eConnect® mobile app to connect with the program anywhere, at any time.

Download on the App Store | GET IT ON Google Play

MetLife Legal Plans

Legal services can be costly and difficult to navigate. MetLife Legal Plans provides you access to experienced attorneys for a wide range of personal legal matters. Network attorneys are available in person, by phone or by email. You can also use online tools to address certain matters on your own.

For covered matters, you have unlimited access to network attorneys with no waiting periods, deductibles or claim forms. You may also use an attorney outside the network and receive partial reimbursement based on the plan's reimbursement schedule. Coverage includes your spouse and dependent children.

Flexible Plan Options

- High Plan: $11.08 bi-weekly
- Low Plan: $9.69 bi-weekly

Premiums are paid through payroll deduction. For matters that are not covered but are not specifically excluded, the plans provide up to four hours of network attorney services each year.

When you need help with a personal legal matter, MetLife Legal is there for you to help make it a little easier. For added protection, your spouse and dependent children are also covered.

Examples of Covered Legal Matters

- Getting married
- Starting a family
- Buying, renting, or selling a home
- Addressing identity theft
- Caring for aging parents
- Sending children to college

Estate Planning

MetLife's online tools allow you to create wills, living wills and powers of attorney. After answering questions about yourself, your family, and your assets, you may be able to create these documents online in as little as 15 minutes.

FraudScout Credit Monitoring

FraudScout is included with the High Plan. This service monitors all three credit bureaus and provides alerts based on activity associated with your Social Security number. It also includes one-click access to a credit report.

To learn more, visit info.legalplans.com and enter access code 9904329 for the High Plan or 9904327 for the Low Plan. You may also call 1-800-821-6400, Monday through Friday, from 7 a.m. to 7 p.m.

Pet Insurance

Discount Programs

Pets are an important part of our families, and unexpected accidents or illnesses can result in significant expenses. Pet insurance is available through MetLife to help provide financial support for eligible veterinary care related to covered accidents and illnesses.

Flexible and Customizable Coverage for Cats and Dogs

You choose the plan that works for you with flexible coverage options. In addition, each pet's premium will be unique based on the age, breed, location, and gender as well as the coverage amount you select.

- Deductible options from $0 - $2,500
- Annual limit options from $1,000 – unlimited
- Reimbursement options from 65% - 100%
- Use any licensed vet of your choice



Pet Insurance Covers:

- Accidental Injuries
- Illnesses
- Exam Fees
- Surgeries
- Medications
- Ultrasounds & X-rays
- Diagnostic Testing
- Hospital Stays

How Pet Insurance Works

1. **Get Quote—**call MetLife at 1-800-GET-MET8 or visit **www.metlife.com/mybenefits**. Enter **Blessing Health System** in the text box and provide your pet's age, breed, gender, and zip code
2. **Enroll**—Select the coverage that is best for your pet
3. **Pay**—Premiums will be charged to your personal bank account or credit card; **they will not be deducted from your paycheck**
4. **Use**—Take your pet to the vet
5. **Pay the vet bill**
6. **Get Reimbursed**
    - Submit your claim and bill to MetLife via the online portal, email, fax or mail
    - Receive reimbursement for your claim according to the terms of your plan

Retirement Savings Plans

It's easy to get caught up in the present, but it's also important to look ahead. Start investing in your future - and yourself - with help from the Plan and Fidelity.

Features	Blessing Health 403(b) Plan	Denman Services, Inc. 401(k) Plan
Contributions	You may contribute up to 90% of your eligible compensation as pre-tax and Roth contributions and, up to 10% of your eligible compensation as after-tax contributions.	You may contribute up to 90% of your eligible compensation as pre-tax and Roth contributions.
Employer Contributions	Blessing Health will match 100% of the first 3% of contributions you make to the plan.	Blessing Health will match 100% of the first 4% of eligible pay you contribute to the plan.
Vesting	You will be 100% vested immediately in all employee contributions. Employer matching contributions will follow a 5-year step vesting schedule.	You will be 100% vested immediately in all employee & employer contributions.
Automatic Enrollment	You will be automatically enrolled in the Plan at a contribution rate of 3% of your pretax eligible earnings.	You will be automatically enrolled in the Plan at a contribution rate of 3% of your pretax eligible earnings.
Investments	The Plan offers you a range of options to help you meet your investment goals. You can select a mix of investment options that best suits your goals, time horizon, and risk tolerance. Descriptions of the Plan's investment options and their performance are available online at **www.netbenefits.com.**	
Rollover Options	You can roll over retirement plan accounts you hold from a previous employer into the 403(b) or 401(k) Plan.	
Online Beneficiary Designation	It's important to designate a beneficiary for your plans. Log on to **www.netbenefits.com.** Click on the "Profile & Settings" icon in the upper right-hand corner, then select "Beneficiaries" and follow the online instructions to designate your beneficiary online.	
One-on-One Consultations	Fidelity Workplace Financial Consultants are available and can help with enrollment, asset allocation, retirement planning and other questions you have about the Plan. Call **800-642-7131**, scan the QR code or visit **www.fidelity.com/schedule** to schedule a complimentary appointment.	
Accessing Your Account	Access your Plan account online at **www.netbenefits.com.** Download the NetBenefits® app from the App Store® or Google Play™ Store to access your account on your mobile device. Fidelity is here to help! If you have questions, call **800-343-0860**.	

Investing involves risk, including risk of loss.
This document provides only a summary of the main features of The Blessing Health Retirement Plans, and the Plan Documents will govern in the event of discrepancies.

Paid Time Off

Blessing offers a generous accumulation of paid time away from work. The PTO bank is a shared bank for vacations, holidays, personal, and sick time. Employees eligible for the PTO benefit will begin accruing on the date of hire or transfer into an eligible status; accrual rate will increase based on years of service. PTO will accrue on the basis of hours worked up to a maximum of 80 hours per pay period. PTO hours will not count toward overtime eligibility.

PTO Hours Must be Used:

- For hours missed from a regular work schedule due to unpaid leave, FMLA, illness, and personal days.
- For the first three (3) days missed due to a work-related injury.

PTO Hours Are Not Required to be Used:

- For the six recognized holidays
- For hours missed from a regular work day. For example, leaving for an appointment, to attend an activity at a child's school, or leaving early for the day.
- When a scheduled employee is absent at our request (AOR), those hours missed will be added to the Hours worked calculation for PTO accrual during that pay period.
- When an employee is receiving other compensatory benefits (i.e. short-term disability, long term disability or worker's compensation wage benefits).
- As a supplement to other wage benefits. For example, an employee who is receiving a 75% short term disability benefit has the option to supplement the remaining lost wages with PTO Disability.
- PTO Banks at or above the maximum limit will no longer accrue additional PTO hours until the employee's PTO balance is below the maximum. Employees who fall into this category will no longer be eligible to sell PTO.

PTO ACCRUAL SCHEDULES

Employees hired before 1/1/2017		
Years of service	PTO Accrual Rate Per Hour Worked	Max Hours You Can Have In PTO Bank
Part Time Employees		
5-9 Years	.1077	224
10-14 Years	.1192	248
15-19 Years	.1269	264
20+ Years	.1346	280
Full Time Employees		
6-11 Years	.1154	340
12+ Years	.1346	340

Employees hired after 1/1/2017		
Years of service	PTO Accrual Rate Per Hour Worked	Max Hours You Can Have In PTO Bank
0-4 Years	.0885	184
5-9 Years	.1077	224
10-14 Years	.1192	248
15-19 Years	.1269	264
20+ Years	.1346	280

Carrier Contacts

Do you have a question about your coverage? Contact your carriers directly for help with benefits questions, claims processing, finding a provider, obtaining an ID card, and more!

Contact Information			
Benefit	**Provider**	**Website**	**Phone Number**
Medical	CURRENT HEALTH SOLUTIONS	www.currenthealthsolutions.org/blessing	855-247-3233 **Group Number: BHSHSP**
Health Savings Account (HSA)	mychoice accounts	https://businessolver.com/mychoice-accounts/	855-505-7593
Rx	Optum Rx®	www.optumrx.com	855-896-9779
Voluntary Benefits	Lincoln Financial Group®	www.mylincolnportal.com	800-423-2765
Dental	DELTA DENTAL	www.deltadental.com	800-323-1743
Vision	vsp VISION	www.vsp.com	800-877-7195
Life and Disability	Lincoln Financial Group®	www.mylincolnportal.com	800-210-0268 **Group Number: 09-LF0975**
FMLA	Lincoln Financial Group®	www.mylincolnportal.com	To request leave: 888-605-1129
Permanent Life Insurance with Long Term Care	TheStandard	www.standard.com/ahl/mybenefits	800-521-3535
Pre-Paid Legal and Identity Theft	MetLife	www.info.legalplans.com	800-821-6400 Group Number: 0173638
Pet Insurance	MetLife	www.metlife.com/mybenefits	800-438-6388
Retirement	Fidelity INVESTMENTS	www.netbenefits.com/blessinghealthsystem	800-343-0860
EAP	supportlinc	www.mysupportlinc.com	1-888-881-5462

Glossary of Terms



Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service. The copay does not count toward your deductible but does count toward your annual out-of-pocket maximum.

Deductible

The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay for certain services. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)

Evidence of Insurability (EOI)

EOI is an application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage. EOI may be required for life and/or disability insurance elections.

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you have to pay per year for covered healthcare services. When you have spent this amount in your plan year on deductibles, copayments, and coinsurance for in-network care and services, your health insurer will pay for 100% of your covered healthcare services. Each medical plan is assigned an out-of-pocket maximum.

Scan to view Glossary of Health Coverage and Medical Terms

Health Care Reform Update

The Affordable Care Act (or ACA) continues to impact health insurance plans for employers like Blessing Health System. For the company, it means we continue to comply with all applicable health plan coverage and administration requirements and pay all applicable taxes and fees as required by the ACA.

For individuals, since 2019 there is no longer an ACA tax penalty for those who do not maintain health insurance coverage. However, individuals still have the ability to purchase coverage through the ACA Health Insurance Marketplace (www.healthcare.gov) and premium subsidies for that coverage remain available to qualifying individuals.

As a reminder, Blessing Health System pays the majority of the cost for the health care coverage we offer to eligible employees. It's also important to note that, because you are eligible for coverage through Blessing Health System, you may not qualify for premium subsidies if you choose to purchase a plan through the Marketplace. We encourage you to evaluate all your coverage options and compare their costs to make the best choice for you and your family.

Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (PPACA or ACA) requires health plans to provide consumers with information about health plan benefits and coverage in a simple and consistent format called a Summary of Benefits and Coverage (SBC). The purpose of the SBC is to help consumers better understand the coverage they have and allow them to easily compare different coverage options. It summarizes key features of the plan, cost-sharing provisions, and coverage limitations and also provides coverage examples. A Uniform Glossary explaining the most common terms used in health insurance is also available.

SBCs are available in Virtual HR or you may request a paper copy by contacting Human Resources.

Important Regulations

Patient Protection – Patient Access to Obstetrical and Gynecological Care

You do not need prior authorization from Current Health Solutions or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Contact Meritain for a list of participating health care professionals who specialize in obstetrics or gynecology.

Women's Health and Cancer Rights Act

On October 21, 1998, the Women's Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. As the Act requires, we have included this notification to inform you about the law's provisions.

The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:
1. Reconstruction of the breast on which the mastectomy has been performed, 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, 3. Prostheses, 4. Treatment of physical complications of all stages of mastectomy, including lymphedema. This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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).

Health Insurance Portability and Accountability Act (HIPAA) – State Children's Health Insurance Program (SCHIP)

Loss of other coverage: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Medicaid or SCHIP coverage: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New dependent: 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or SCHIP premium assistance: If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Coverage

CHIP is short for the Children's Health Insurance Program—a program to provide health insurance to all uninsured children and who are not eligible for or enrolled in Medical Assistance. CHIPRA is the reauthorization act of CHIP which was signed into law in February 2009. Under CHIPRA, a state CHIP program may elect to offer premium assistance to subsidize employer-provided coverage for eligible low-income children and families. All employers are required to provide employees notification regarding CHIPRA. Please refer to the following pages for the full notice.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 1, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website:
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program
(HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 1, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website:
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program
(HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 1, 2026, or for more information on special enrollment rights, contact either:

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

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

(Creditable Coverage Notice) Important Notice from Blessing Health System About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Blessing Health System has determined that the prescription drug coverage offered by OptumRx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. 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 while enrolled in Blessing Health System coverage as an active employee, please note that your Blessing Health System coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Blessing Health System coverage as a former employee.

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

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

For More Information About 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 Blessing Health System 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: January 1, 2027
Name of Entity/Sender: Blessing Health System
Contact: Human Resources

Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Notice

Blessing Health System sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of ABC Company, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Blessing Health System, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.
If you have any questions about this Notice or about our privacy practices, please contact Human Resources.

Our Responsibilities
We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet.
Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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 visitinghttps://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html .
To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Notice

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

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment in 2027 is more than 9.96%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable in 2027 if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income.[1,][2]

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

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.
Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. If you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

[1] Indexed annually.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.



This benefits guide covers only the highlights of Blessing Health System's benefit programs. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. Blessing Health System intends to continue these programs but reserves the right to change or end them at any time. Participation in the programs does not imply a contract of employment.