Frequently Asked Questions about the Blessing Health System 2026 Total Rewards Package

Human Resources: 217-223-8400, extension 6850, option 5 or HRTotalRewards@blessinghealth.org

ELIGIBILITY	
Q: I'm a per diem employee. Am I eligible for benefits?	**A:** Per diem employees are not eligible for company provided benefits, voluntary benefits, or PTO. They are however eligible to participate in our retirement plan, have a membership at the Wellness Center, access the Employee Assistance Program, and take advantage of Work Life benefits through BeneConnect.
Q: I am under the age of 26 and still covered under my parent's benefits. What happens when I turn 26?	**A:** The loss of coverage under your parent's benefits will be a Qualifying Life Event to elect benefits with Blessing as long as you are in a benefit eligible status.
Q: I have other health insurance coverage and don't need Blessing's health insurance. Can I still elect dental and vision and other voluntary benefits?	**A:** Yes. Our plans are all separate. You are not required to elect health in order to enroll in dental, vision, or other voluntary benefits.
Q: How many hours does an employee have to work to qualify for benefits? And when is an employee considered full-time?	**A:** In order to be eligible to enroll in benefits, an employee must be regularly scheduled to work 16 hours per week or; 32 hours per pay period. Full time employment starts when an employee is regularly scheduled to work at least 32 hours per week or; 64 hours per pay period.
Q: My spouse and I both work for Blessing Health System. Can we both cover our kids on benefits?	**A:** No, a dependent can only be covered once under a plan. Also, if a dependent child also works for Blessing and is eligible for benefits, they can't also be a covered dependent under Life Insurance and Accidental Death & Dismemberment benefits.

HEALTH	
Q: My spouse and I both work for Blessing Health System. Do we each need to make an election for our own health plan?	**A:** No, married employees may elect coverage under one spouse. You don't have to elect separate plans.
Q: My spouse is self-employed and doesn't have health insurance. Can they be on my health plan?	**A:** Yes. A self-employed spouse is eligible for primary coverage under the Blessing health plan. However, spouses with access to employer sponsored coverage are required to enroll in that plan first, regardless of the cost, for primary health insurance coverage but are able to obtain secondary coverage on Blessing's plan if they chose to.

Q: I know our health insurance pays better if we are able to see a Blessing provider. But what happens if Blessing doesn't have the kind of specialist I need?	**A:** While we have providers in almost all specialties, there might be a time when you need to see a provider that is not affiliated with Blessing. Blessing's insurance provides In-Network coverage through the Current Health Solutions Network and also through First Health. In the event you need to see a provider in the Tier 2 Network, you will still have excellent coverage but it will be at a higher co-pay (on the Standard plan) and also subject to a higher deductible. Remember that even if you have to see a Tier 2 provider, that doesn't mean you need to get additional services at their facility. You can always ask for your diagnostic services or procedures to be performed at Blessing. As a reminder, Tier 1 provider coverage is not guaranteed. The tier 1 benefit is an incentive that we can offer to our employees because we can control the cost of care. As a health plan, we are continually looking at the providers needed to manage the health care needs of our community.
Q: What's the difference between the Standard and Enhanced plans?	The new Enhanced plan has a lower Tier 2 deductible and Out of Pocket Maximum than the Standard plan. This plan would benefit members who routinely seek care and services at Tier 2 providers and facilities because it provides 80% coverage at Tier 2 locations.
Q: Do the deductibles apply across Tier 1, 2, & 3 or are they separate?	**A:** On the High Deductible Health Plan the deductibles apply across all three networks tiers. On the Standard & Enhanced Plan, only tier 1 and tier 2 deductibles apply across those network tiers.
Q: Why are the out of pocket expenses higher for the standard plan then the high deductible plan?	**A:** The out of pocket expenses are higher on the standard plan because it has a lower deductible and less out of pocket expenses upfront. The High Deductible Health Plan has a significantly higher deductible which has to be met before the health insurance policy begins paying claims.
Q: My child goes to college or lives away from the area and needs to see a provider. How does that work so I don't have to pay out of network charges for them?	**A:** If your child resides outside of the Current Health Solutions primary service network, you would need to update your dependent's mailing address to the location where they reside. This will allow your dependents to use the First Health Network for providers. Services provided by a First Health Network provider will be covered at the tier 2 benefit level.
Q: How does the coverage work for high deductible once the out of pocket requirement is met?	**A:** Once your deductible and out of pocket maximums are satisfied, the health plan will pay covered services at 100%.
Q: If Blessing doesn't have a specialist that we require, do we have to pay a tier 2 copay/deductible?	**A:** If Blessing does not have the specialist that you need to visit, the visit would be covered at tier 2 or tier 3 depending on the providers network status and the co-pay/deductible for that network tier would apply.

Q: Can you explain deductibles and Out of Pocket Maximums? For example, on the Standard Plan at Tier 1 providers, the out of pocket $14,700 for employee and spouse. Is that $7,350 each or, both combined have to hit $14,700?	**A:** The deductibles and out of pocket expenses are non-embedded. This means that the deductible and out pocket max for that coverage level must be met. On the standard plan, the employee plus spouse deductible is $1,00.00 and the out of pocket maximum is $14,700. The plan will not pay for services that apply to the deductible until the employee + spouse deductible is met. The total out of pocket maximum is $14,700. This includes the deductible. Out of pocket expenses will accumulate until the total $14,700 is met. As long as the total spent $14,700, it doesn't matter how much of that total applies to the spouse or employee.
Q: Do I still have to make a co-pay if I have already met my deductible?	**A:** Co-pays do not end if your deductible is met; however, they do end if you have met your out of pocket maximum on the Standard & Enhanced plans. As a reminder, the High Deductible plan does not have co-pays. All expenses apply first to your deductible and then your out of pocket maximum.
Q: How do we find specialists that are in Tier 2 if we don't have coverage under Tier 1 for them?	**A:** To find network providers under Primary Care or Specialties, you can call Current Health Solutions, Member Services at 855-247-3233 or visit their website at www.currenthealthsolutions.org.
Q: Is there still a $30 copay for the walk-in clinic?	**A:** No, a visit to the Walk In Clinic will not require a co-pay if you are on the Standard or Enhanced Plan.
Q: What locations can we use and not have a co-pay?	**A:** On the Standard & Enhanced Plans, a co-pay is not required at Tier 1 Primary Care Providers, the Blessing Walk In Clinic, the Blessing Express Clinic, or the Blessing Be Well Employer Clinic. Please refer to the Total Rewards Guide for more information on co-pays.
Q: What do you do when you go to a Tier 1 provider but they do a lab through a tier 2 lab company I didn't know about? It's frustrating to get a bill I didn't see coming.	**A:** As a consumer, anytime you have a lab or diagnostic service, you have the responsibility to ask if the test will be read or evaluated by an in-house Blessing provider or sent out to a Tier 2 provider. Human Resources can't guarantee that there will always be a tier 1 option but asking the questions will allow you to prepare for the expense or consider other options.

WELLNESS

Q: Is the Wellness Program mandatory?	**A:** No, this is a voluntary program but there are several incentives for completing it. Discounted health insurance & access to wellness education are a few!
Q: Does my spouse have to participate in the Wellness Program?	**A:** No. Spouses are no longer required to participate in the Wellness Program.
Q: Do you actually need to do anything to sign up for the Wellness Program each year?	**A:** In order to remain eligible for Wellness incentives, you have to complete the program requirements by September 30th annually. Failure to complete the requirements will make you ineligible for the Standard Plan with the wellness incentive for the following calendar year.
Q: What are the premium savings for completing wellness requirements?	**A:** The annual premium savings can vary based on your coverage level and employment status. For example, a full-time employee covering their family will save over $2,400 annually in premiums.

PHARMACY

Q: When do we choose the Blessing Specialty Pharmacy vs Browns?	**A:** Specialty pharmacy is typically required when the medication is a high dollar medication or a medication used to treat chronic conditions. If a prescription is sent to one of Blessing's owned retail pharmacies and the medication needs to be filled at a specialty pharmacy, the Blessing retail pharmacy will send the prescription to the Blessing specialty pharmacy to be filled.
Q: If we currently have a prescription through Optum, does that need to be switched to the Blessing Specialty?	**A:** Yes, effective 1/1/2025, all Specialty medications should be filled with Blessing Specialty Pharmacy. If Blessing does not have the medication available, they will send it to Optum Specialty Pharmacy.
Q: On the High Deductible plan, how are prescriptions covered? For example, on generics, once I have met my deductible, do I pay 10% or is that what the health plan will pay?	**A**: Employees enrolled on the High Deductible Health Plan must satisfy the deductible before prescriptions are covered. Once the deductible has been satisfied, the employee will pay a co-insurance amount, based on the type of medication being filled, until you have met your out of pocket maximum.

BE WELL WITH DIABETES

Q: I hear that the $25.00 per pay period per person fee is after taxes. If this a medical expense why isn't this pre-tax like our premiums and flex spending accounts?	**A:** The $25.00 charge is not a health insurance premium. It is a membership fee for the Be Well with Diabetes Program.
Q: Is the Diabetes Management program open enrollment all year?	**A:** Yes, you can enroll in the diabetes management program at any time.

SUPPLEMENTAL HEALTH BENEFITS

Q: On the Accident and Critical Illness benefits, can you get reimbursed for A1C test if you are also on the Be Well with Diabetes program? Would you still get the reimbursement if you didn't technically pay for the service?	**A:** Employees and covered dependents enrolled in the Critical Illness or Accident insurance program are eligible for health incentives through Lincoln Financial. The health incentive reimbursement is based on eligible assessments and not on what was paid for the service provided.
Q: There are several tests listed on the Critical Illness and Accident Insurance Health Assessments reimbursement forms. For clarification, you can only claim one of those test a year, not one of each test per person, correct?	**A:** Eligible employees and dependents, enrolled in the Critical Illness or Accident Health Insurance, can claim one health assessment, per plan benefit, per calendar year.
Q: Can you claim one health assessment for the Accident and Critical Health Assessment?	**A:** Eligible employees and dependents enrolled in the Critical Illness and Accident Insurance benefit are eligible to claim the health assessment benefit under each plan up to the maximum benefit.

PRE-TAX SAVINGS OPTIONS

Q: I'm confused about the difference between an HSA and an FSA. Can I have both? Does that money rollover if I don't use it all?	**A:** HSA stands for Health Savings Account. You can only contribute to an HSA if you are enrolled in a High Deductible Health Plan. HSA's do rollover from year to year. FSA stands for Flexible Spending Account. We offer two types of FSA's. You can have a medical flex account and/or a dependent care flex account. FSA's don't roll over from year to year so you need to be conservative with the amount you decide to set aside on an annual basis. Our medical FSA has a rollover period (until March 15th of the next year) in case you don't use the entire amount you set aside by December 31st. Dependent care accounts can be used for child care expenses that you incur because you work. Both Medical FSA's and HSA's can be used for any out of pocket medical, dental, and vision expenses that you or your tax dependents incur. The amount you can contribute annually to these accounts and the expenses that qualify are determined by the IRS. You can have both an HSA and an FSA. But, if you have both, your FSA will be considered "limited purpose" and can only be used for dental and vision expenses. Our Medical FSA account is administered locally by GHS Employee Benefits. They can be reached at 217-222-0304, ext. 311. Dependent Care is administered internally by the Blessing Fiscal Services Department and Health Savings Accounts are administered by the MMA Spending Account Service Center.
Q: Can the Flex Spending contribution amount be increased during the year?	**A:** Your Medical flexible spending account election cannot be changed throughout the year unless you experience a Qualifying Life Event.
Q: Can HSA dollars be used for health insurance premiums in retirement?	**A:** For a full listing of HSA eligible expenses, please refer to IRS publication 969 or seek the guidance of a qualified tax preparer.
Q: Can you have an HSA without doing the high deductible health plan?	**A:** No, in order to contribute to an HSA, you must be enrolled in a High Deductible Health Plan. If you have funds remaining in an HSA, you can continue to use the balance for out of pocket medical, dental, & vision expenses but, you can only contribute to an HSA if you are currently enrolled in a high deductible health plan.
Q: Where can we get more information on Flexible Spending Accounts for childcare?	**A:** You can locate additional information on Dependent Care Flexible Spending in the 2026 Total Rewards Guide or by referencing IRS Publication 503. For information on balances or how to use your account you may also contact the Blessing Fiscal Services department.

LEAVE & DISABILITY

Q: How do I take a leave? Can I use my disability coverage?	**A:** Employees should initiate a leave request approximately 30 days prior to an anticipated leave when possible. To start a claim, employees should start a leave request in Kronos and contact Lincoln (via phone at 888-605-1129 or by logging into mylincolnportal.com). Lincoln will be able to walk you through the process and determine if your eligible for Family Medical Leave and Short-Term Disability. If you need to use your disability coverage, first, you'll need to have a doctor certify your condition and be approved. Then there's a short waiting period before disability payments begin. Once the waiting period ends, your short-term disability benefit will replace a percentage of your pay each week, up to the duration the plan allows. Short Term Disability can pay for up to 24 weeks as long as your physician requires you to be off work. If your condition persists beyond that, you may be able to apply for Long Term Disability. Long Term Disability benefits are offset by Social Security and other disability benefits.

DENTAL

Q: My dentist isn't in network with Delta Dental. Can I still go to them? How can they get added to the network?	**A:** As with all your benefits, you see the greatest cost savings by choosing an in-network provider. While Delta Dental's network of providers is limited, they cover Out of Network dentists at the 95th percentile so no matter where you go, you'll get a great benefit. The choice to enroll in the Delta Dental Network is at the sole discretion of each dental practice.
Q: Do we have coverage for orthodontics?	**A:** Delta Dental provides both adult and child orthodontia benefits for employees and dependents enrolled on the Premier Plan. There is a lifetime maximum of $1,500.00 dollars per enrolled individual.
Q: Is there a waiting period before you can get dentures?	**A:** No, Delta Dental does not have a waiting period for denture benefits.
Q: How do we find out who is in-network with Delta Dental?	A: To determine if a provider participates in the Delta Dental Network, please visit www.deltadental.com or call customer service at 1-800-323-1743.

VISION

Q: Does the vision insurance cover medical issues of the eye?	**A:** No, our vision plan is a corrective vision plan and does not cover medical issues of the eye.
Q: What does the VSP buy up cover?	**A:** They Buy-Up Plan has an increased allowance for contacts and frames. For more information visit VSP.com.

PAID TIME OFF (PTO)

Q: Does my Paid Time Off (PTO) roll over from year to year?	**A:** Yes. PTO rolls over from year to year. Maximum hours that you can have in your bank and the amount of PTO that you accrue increases with your years of service. See the Total Rewards Guide for more information on PTO.
Q: I just started and I am getting married in a few months. I want to save my PTO for my honeymoon. Do I have to use my PTO when I'm off work?	**A:** PTO will automatically be applied for any scheduled time that you miss from work. However, there are a couple of situations where you can let your leader or timekeeper know that you don't want to use PTO. These situations include an unplanned partial day missed from work (for instance, you have to leave to pick up a sick child) and the six recognized holidays. If you would normally be scheduled to work but it's a holiday and your department is closed, you can elect to NOT use PTO.
Q: Where do we go to do PTO Sell?	PTO Sell can be elected annually during Open Enrollment. The on-line form is located in Virtual HR under the Benefit Enrollment section.

RETIREMENT

Q: Does Blessing match my retirement contributions?	A: Yes! Since we know the first few weeks at a new job are busy, we take care of getting you enrolled in the retirement plan. We automatically enroll you after 30 days of employment at a contribution rate of 3%. Blessing matches that contribution at 100% up to 3% of your eligible compensation. You can increase or decrease this contribution anytime directly with Fidelity. You can reach them at 1-800-343-0860 or log on to www.netbenefits.com/blessinghealthsystem.
Q: I have a retirement plan from old job. How do I move that into my Blessing 403b with Fidelity?	**A:** A few weeks after your start date, you'll get a packet from Fidelity. It's got a lot of great information about the plan but also contains a rollover form that will help you start this process. Your old job's plan will probably have a similar form that you will need to complete for them as well. You can contact Fidelity at 1-800-343-0860 for assistance.
Q: Do the retirement plans have a vesting schedule?	**A:** Yes. The matching contribution on the Blessing 403b is subject to a 5-year vesting schedule that starts after your second year of employment at 40%.
Q: I read that Match Earnings can be converted to Roth thru payroll. Will Blessing be offering this?	**A:** Blessing offers employees the option to contribute to the retirement plan on an after-tax basis through Roth contributions. Roth Contributions grow tax free and no taxes are due when you withdraw the money from your plan in retirement. Participants also have the option to do an In Plan Roth Conversion of their pre-tax contributions. For more information on this option, please contact Fidelity at 1-800-343-0860.