2023

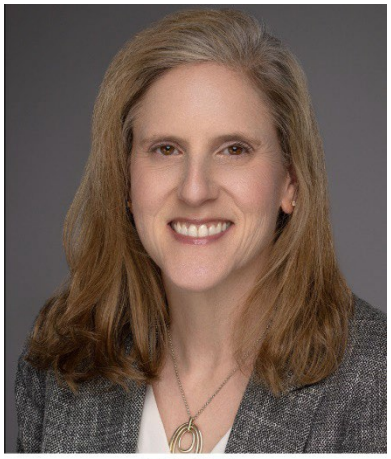
BENEFITS FOR NEW HIRE

Total Health and Wellness Healthcare Benefits Package

MyHR

PARKVIEW HEALTH

Welcome to Parkview Health!


Hallie Custer

We are glad you have chosen to be a part of Parkview Health!

This booklet is intended to help you understand the available Parkview Health benefit plans. Parkview Health is proud to provide access to high-quality benefits that support your health and financial goals as part of your Total Rewards package. Many of these benefits are subsidized or provided to co-workers at no cost. We continue to pursue and offer opportunities to provide you with meaningful benefits that support and provide peace of mind through competitive and comprehensive programs.

There are many important decisions you need to make regarding your benefits, some of which need to be decided within your first 31 days of employment or of becoming benefits eligible. Please review this book carefully to see what choices best meet the needs of you and your family.

The Benefits website is located on Parkview's Intranet site, “The Pulse.” You may click here to link directly to the Total Rewards information. Additional information on all Parkview benefits is in the Human Resources section. You may also contact your Human Resources office for questions.

You are important to Parkview! We are excited that you have joined Parkview Health and hope that you enjoy the many programs that Parkview provides to co-workers.

Hallie Custer

Hallie Custer
Vice President Human Resources

What's Inside this Guide

Voluntary Benefit Plans

Appendix

The documents posted to the Pulse intranet site and made available through links below are part of your plan documents for the Parkview Health System, Inc. employee benefit plans. You should review this information carefully, share it with your covered dependents, and keep this information with other Plan materials for future reference. In the event of a conflict between the official Plan Document and these materials, other components of the SPD, or any other communication related to the Plan, the official Plan Document will govern.

You First

Parkview Health is northeast Indiana's largest not-for-profit healthcare system. We believe in putting people first. That is great news for our patients, but also for our co-workers. We are committed to providing you with comprehensive and competitive benefit options that meet your needs and puts your mind at ease.

Parkview's benefit plans for full- and part-time co-workers are just one piece of your Total Rewards package designed to ensure the welfare of our co-workers and their families. In designing our benefit plans, we seek to provide the right combination of benefits to enable you to optimize your physical, mental and financial health, while balancing factors such as plan costs.

We encourage you to review this booklet and assess your health and benefit needs, build a plan to achieve your goals, and commit to a healthier you! Benefits are a shared responsibility between you and Parkview. Parkview offers comprehensive benefits, but it is your responsibility to understand the programs, ask questions and make decisions appropriate for your needs. Please note this booklet only provides highlights of each of the plans. You will need to refer to each of the plan's Summary Plan Description for more complete and detailed information. Please remember that benefits are a significant part of your total compensation and an important recognition of Parkview's commitment to you. Parkview's benefits and compensation make up your total rewards. It is one reason people in our area want to work for Parkview. We are glad you are here!

Benefits Timeline

You are ***automatically**** enrolled in:

- ☐ Group Term Life Insurance (if eligible) – you must designate a beneficiary(ies)
- ☐ Short Term and Long Term Disability (if eligible)
- ☐ Retirement Contribution Plan – you must designate your beneficiary(ies) and investment selections

You have ***31 days*** from your eligibility date* to enroll in:

- ☐ Medical, dental, and/or vision coverage for you and your eligible dependents
- ☐ Parkflex Healthcare and/or Dependent Care Flexible Spending Accounts
- ☐ Supplemental Life for additional coverage for yourself (without providing a health statement.)
- ☐ Dependent Life coverage for your spouse and/or dependent child(ren) (without providing a health statement.)
- ☐ Critical Illness and/or Accident Coverage

At any time, you may:

- ☐ Enroll or make changes to your 403(b) Plan by going to Lincoln Financial Group's website at www.lfg.com.
- ☐ Update your retirement plan or life insurance beneficiaries
- ☐ Enroll in additional Voluntary Benefits not listed above

*All enrollments are based upon meeting eligibility criteria for each plan. Your eligibility date is your date of hire or benefits status change. If you have questions on how to enroll for benefits in MyHR, you will want to click here for enrollment information that is included on Human Resources Total Rewards Pulse site.

Benefits Eligibility and Enrollment Deadlines

Below is a quick reference for each of the benefits, who is eligible, and enrollment requirements. You will want to refer to the plan's Summary Plan Descriptions for a complete description of the plans.

BENEFIT	*ELIGIBLITY*	*ENROLLMENT DEADLINE*
Health Care	0.6 to 1.0 FTE	Required within 31 days of hire date or date of status change.
Parkflex – Health and Dependent Care Flexible Spending Account	0.6 to 1.0 FTE	Required within 31 days of hire date or date of status change.
Critical Illness & Accident Insurance	0.6 to 1.0 FTE	Required within 31 days of hire date or date of status change.
Short Term Disability	0.6 to 1.0 FTE	No enrollment is required.
Long Term Disability	0.8 to 1.0 FTE	No enrollment is required.
Basic Life and AD&D Insurance	0.6 to 1.0 FTE	No enrollment is required. Beneficiary information is required within 31 days of hire date or date of status change.
Supplemental Life Insurance	0.6 to 1.0 FTE	Enrollment is required within 31 days of hire date or benefit eligibility without providing a statement of health.
Dependent Life Insurance for Spouse and Children	0.6 to 1.0 FTE	Enrollment is required within 31 days of hire date or benefit eligibility without providing a statement of health.
Voluntary AD & D Insurance	0.6 to 1.0 FTE	May enroll anytime.
403(b)/401(k) Plan	1 hour	May enroll anytime.
Retirement Contribution Plan	1,000 hours	No enrollment is required.
Match Plan	2 years (1,000 hours/ year)	No enrollment is required. Will be dependent upon co-worker's 403(b) Plan elections
VTO	.01 to 1.0 FTE	No enrollment is required.
PTO	.06 to 1.0 FTE	No enrollment is required.
Voluntary Benefits	0.6 to 1.0 FTE	May enroll anytime.
Lifestyle Benefits	0.6 to 1.0 FTE	No enrollment required.

Healthcare Plans

Parkview Health offers healthcare plans that assist with the payment of expenses for medically necessary care and treatment resulting from an illness or accident. The Plans will also help you stay healthy by covering certain costs of preventive care such as physical examinations, dental care and cancer screening tests.

Parkview offers two medical plans for eligible full- and part-time co-workers. Eligibility for each of the plans is based on the co-worker's permanent address. More information regarding eligibility for each of the plans is available under the Medical Plan section. A dental and vision plan is also offered. Each of the plans are "stand alone" plans meaning that you elect each of the plans that you desire coverage. The plans you elect will be in effect for the entire plan year unless you experience a qualified status change in your work or family situation.

Am I eligible for healthcare benefits from Parkview Health?

Parkview offers medical, dental and/or vision coverage to eligible co-workers with a 0.6FTE or greater.

When can I Enroll?

To enroll in the medical, dental, and/or vision plans or to make changes in your coverage level, you must complete your enrollment within 31 days from your date of hire, status change or qualifying change in family status and provide the Eligibility Documents for your Dependents. You will be using "MyHR" to enroll for medical, dental, and/or vision coverage. You can access MyHR at www.myhr.parkview.com from any computer or mobile device with internet access including your own personal computer by using any browser (Internet Explorer must be version 8 or higher). **If you do not make a health plan election within 31 days of initial eligibility, you must wait until the next annual enrollment period to do so, unless you experience a qualifying event.**

Who are my eligible dependents that can be enrolled in each of the healthcare plans?

Parkview Health offers you the opportunity to cover eligible dependents. Please reference the chart below to see if your family member is eligible for coverage as a dependent on your health plans. If you enroll your eligible dependents in Parkview's medical, dental, and/or vision plans, you must provide documentation supporting their eligibility for coverage within 62 days of your date of hire or date of status change. The eligibility documentation that meets your situation should be sent directly to Signature Care.

Family member	Eligibility Requirements	Acceptable Documentation
Spouse	▪ Must be legally married. ▪ Must not be offered employer sponsored health coverage elsewhere – for medical coverage only. ▪ See "Working Spouse Rule" below for more detail	▪ Marriage license or certificate
Children	▪ Under age 26, regardless of their educational, marital, residential or work status ▪ Biological child(ren) ▪ Other qualified child(ren), including legally adopted	▪ Birth certificate for each dependent child ▪ Adoption papers for each dependent child that is adopted or waiting

	children, child legally placed for an adoption, stepchildren, or children for whom you have legal court appointed guardianship	adoption and is legally placed ▪ Court documentation for proof of legal guardianship for dependent children ▪ Divorce decree indicating which spouse pays healthcare expenses for dependent children

How do I enroll in benefits?

You will make your elections using the MyHR portal from any computer or mobile device. The portal can be found at http://myhr.parkview.com For additional details, please click here

When does my healthcare coverage begin?

Your medical, dental and/or vision benefits will be effective on the first day of the month following your date of hire or date of your qualifying status change if you enroll **within 31 days** of the event. If your date of hire or date of your qualifying status change is on the first day of the month, coverage will be effective on that day. Annual Open Enrollment elections are effective January 1 of the new plan year.

What happens if I have a qualifying life event?

You will not be able to change your health plan coverage during the plan year unless a qualifying event occurs. There are two types of qualifying events: (1) family status changes and (2) employment status changes. If you experience a qualifying life event, you have 31 days to make a change to your benefit coverage. If you miss this deadline, your next opportunity to change your benefit coverage will be during the next annual open enrollment period. MyHR can be used to change benefits elections due to certain status changes, including marriage, divorce, birth, adoption/legal guardianship or gain or loss of other coverage.

How do I pay for my medical, dental, and vision plans?

The applicable premium for the coverage you elect will be withheld on the first paycheck of the month in which your coverage becomes effective. Medical premium rates are provided on page 10. Premiums are deducted pre-tax from your paycheck.

As a new hire, how can I take advantage of the discounted medical premiums with the MyWell-Being program?

As a new hire, your medical premiums will be the discounted MyWell-Being rates for 2023. This allows you to receive the discounted medical rates from the date of hire or when you become benefit eligible. Depending on your hire date, you may have requirements to meet to earn the incentive for the 2024 plan year. Please watch for emails from the MyWell-Being team for more information.

When does my coverage end?

Coverage will terminate for the following covered co-workers when these events occur:

- For a covered co-worker and their dependents: When you end your employment with Parkview Health or are no longer eligible for benefits, coverage will end on the last day of the month in which your employment ends or the change in status occurs if required contributions have been made.
- For the spouse of the enrolled co-workers: Coverage will end on the date of divorce, dissolution, or legal separation.
- For a dependent child: Coverage will end at the end of the month in which the child no longer qualifies as a dependent.

➢ Medical Plan

As indicated above, Parkview offers two medical plans for eligible full- and part-time co-workers. Both plans offer comprehensive medical coverage with a variety of options to meet your unique needs. Prescription drug coverage is included in both medical plans. Eligibility for each of the plans is based on the co-worker's permanent address.

- The Signature Care Medical Plan is provided for co-workers with a permanent address within a 100-mile radius of PRMC; and,
- The Anthem Medical Plan is provided for co-workers with a permanent address greater than the 100-mile radius of PRMC.

Parkview Health offers a discount to co-workers and their eligible dependents on most Parkview Health facility services. Please see the Medical Care Discount policy located on The Pulse for specific information on services eligible for discounts. The discount is automatically applied to co-worker accounts. To take advantage of the discount for your eligible dependents or to make inquiries regarding services eligible for a co-worker discount, please call Patient Accounting at (260) 266-6700.

Working Spouse Rule for the Medical Plan

Parkview's Working Spouse Rule means that if your spouse is employed and their employer provides medical coverage, even as a retiree, your spouse is not eligible for Parkview's medical plan if they are eligible for their employer's coverage. Please note that Parkview considers certain non-traditional medical coverage options, including but not limited to individual coverage health reimbursement arrangements (also called ICHRAs), offered by other employers to qualify as "medical coverage" available through that employer for purposes of applying the Working Spouse Rule criteria. It is your responsibility to ensure that medical plan coverage is accurate as Parkview Health trusts their co-workers to only cover their spouse when they meet the eligibility criteria and their spouse is not offered or not eligible for medical coverage with their employer. If any information is later found not to be accurate or your spouse was eligible for coverage with their employer, you may be subject to corrective action up to and including termination of employment. The Working Spouse Rule does not affect your spouse's eligibility for dental and vision insurance as well as the Healthcare and Dependent Care Flexible Spending Accounts.

For those co-workers who will elect coverage for their spouse, during the enrollment process in MyHR, you will need to attest that your spouse is eligible for coverage. The examples below may help you identify your own situation:

1	Your spouse is eligible for retiree coverage through their former employer.	As your spouse has coverage through their employer's medical plan, secondary coverage is not available under Parkview Health's medical plan.

2	Your spouse does not have medical coverage because their employer does not offer any medical benefits.	Your spouse is eligible for Parkview Health's medical plan.
3	Your spouse is not presently employed.	Your spouse is eligible for Parkview Health's medical plan.
4	Your spouse is eligible for Medicare coverage.	Your spouse is eligible for Parkview Health's medical plan.
5	Your spouse has medical coverage through their employer and wants to use Parkview Health's plan for secondary coverage.	Your spouse will need to enroll for their employer's medical coverage. Secondary coverage is not available under Parkview Health's medical plan.
6	Your spouse, who is also employed with Parkview Health, is eligible for medical coverage through Parkview Health and is currently enrolled on your plan.	Your Parkview Health employed spouse may continue coverage under your plan.

Medical Premium Rates for 2023

2023 Full-Time Co-worker Medical Plan Contributions (26 pay periods)	***Cost per pay period for health benefits without the MyWell-Being discount***	***Cost per pay period for health benefits with the MyWell-Being discount***	***Difference (Savings) per pay period with the discounted rates***	***Annual value of MyWell-Being discount***
Co-worker Only	$47.54	$34.09	($13.45)	$349.70
Co-worker + Spouse	$180.13	$122.12	($58.01)	$1,508.26
Co-worker + 1 Dependent (Child)	$111.94	$60.04	($51.90)	$1,349.40
Co-worker + 2/more Dependent (Children)	$133.32	$79.88	($53.44)	$1,389.44
Family	$230.50	$167.92	($62.58)	$1,627.08
2023 Part-Time Co-worker Medical Plan Contributions (26 pay periods)	***Cost per pay period for health benefits without the MyWell-Being discount***	***Cost per pay period for health benefits with the MyWell-Being discount***	***Difference (Savings) per pay period with the discounted rates***	***Annual value of MyWell-Being discount***
Co-worker Only	$47.54	$47.54	$0	$0
Co-worker + Spouse	$239.81	$181.18	($58.63)	$1,524.38
Co-worker + 1 Dependent (Child)	$162.16	$107.23	($54.93)	$1,428.18
Co-worker + 2/more Dependent (Children)	$198.08	$142.09	($55.99)	$1,455.74
Family	$313.24	$249.85	($63.39)	$1,648.14

➢ Dental Plan

Parkview's dental plan is provided by Delta Dental and provides coverage for preventive, restorative, major and orthodontic dental care. A schedule of benefits is located on page 54 of this booklet.

Using the Dental Plan

The plan offers you a choice of PPO, Premier, or Non-Network coverage levels.

- To see if your dentist is in the Delta Dental network, visit http://deltadentalin.com or use their mobile app. Please note that you will be able to register for an account with Delta Dental within 7-10 days after the date your coverage is effective and the date you submitted your benefit elections in MyHR.

Using a **network** provider:

- Present your insurance card to the provider at the time of service.
- No claim forms are necessary for network dental services. Your provider should file claims directly with Delta Dental.
- You are required to pay your copay/coinsurance amount to the provider.

Using a **non-network provider**:

- Your provider may require payment for services in full. You may then work with Delta Dental on reimbursement.
- If your provider does not file your claim directly, you may send in a claim using the Delta Dental Claim form which is located on the Pulse within the Total Rewards Site.

Dental Premium Rates for 2023

Full-Time ***Co-worker Contributions***	***Cost per pay period*** ***(26 pay periods)***
Co-worker Only	$5.97
Co-worker + Spouse	$11.31
Co-worker + 1 Dependent (Child)	$11.31
Co-worker + 2/more Dependent (Children)	$18.69
Co-worker + Family	$18.69

Part -Time ***Co-worker Contributions***	***Cost per pay period*** ***(26 pay periods)***
Co-worker Only	$9.85
Co-worker + Spouse	$18.18
Co-worker + 1 Dependent (Child)	$18.18
Co-worker + 2/more Dependent (Children)	$26.26
Co-worker + Family	$26.26

➢ Vision Plan

Parkview Health offers the MetLife Insurance Company's Vision Plan. MetLife's vision plan covers a full range of brands and technologies for lens options. You will also be eligible to take advantage of discounts on non-prescription sunglasses, a second pair of glasses and more. The schedule of vision benefits is on page 55 of this booklet.

Using the Vision Plan

You will have access to an extensive network of ophthalmologists, optometrists and opticians. MetLife uses a national network of retail chains and private practice providers.

- To view MetLife vision plan providers, you may visit www.metlife.com and click on "Find a Vision Provider."
- Once you enroll in the Vision Plan, to locate a MetLife vision care specialist 24 hours a day, seven days a week, go to www.metlife.com/mybenefits and click on find a Vision Provider or call MetLife Vision at 1-855-MET-EYE1 (1-855-638-3931) for access to our 24/7 Interactive Voice Response system.

Vision Premium Rates for 2023

MetLife Vision Care Plan Co-worker Contributions (26 Pays)				
Co-worker Only	Co-worker + 1 Dependent (Spouse)	Co-worker + 1 Dependent (Child)	Co-worker + 2/more Dependent (Children)	Family
$ 3.03	$ 5.70	$ 5.70	$ 7.95	$ 7.95

Short Term and Long Term Disability Plans

➢ Short Term Disability

Parkview Health provides Short Term Disability benefits to eligible co-workers whose non-work-related illness or injury prevents them from performing their job duties. The Hartford is the administrator for this Plan. Co-workers with an FTE of 0.6 or higher are eligible for this benefit. Enrollment in this plan is automatic.

When does my Short Term Disability coverage begin?

If you have an FTE status of 0.6 or greater, you are eligible for coverage under the Plan the first day of the month following 30 days of employment. You do not need to enroll for coverage in the Short Term Disability plan.

What is my cost for the Short Term Disability Plan?

Parkview Health pays the full cost of your coverage under this plan. There is no cost to you.

If I need to be away from my job, when will Short Term Disability benefits begin?

Upon The Hartford's approval of the claim, benefits under the Plan will begin after you complete the elimination period. The elimination period is:

- 5 calendar days for pregnancy, surgery or illness; or
- 0 days for injury.

You will be required to use PTO during this period. If you do not have PTO, the elimination period will be unpaid.

What benefit will I receive if I am unable to work?

After the elimination period has been satisfied, you will receive a weekly benefit of 66 2/3% of your base salary if you are considered disabled and unable to work. The maximum weekly benefit is $2,500. The maximum benefit period is 26 weeks. Short Term Disability payments are paid by Parkview Health's payroll department on regularly scheduled paydays. The benefit is considered taxable income.

➢ Long Term Disability Plan

Parkview Health provides Long Term Disability benefits to eligible co-workers who are considered disabled and unable to return to their position. The Hartford is the administrator for this plan. If you meet the eligibility requirement for this plan, your enrollment in this plan is automatic.

What is the eligibility requirement for the Long Term Disability Plan?

You are eligible for the Long Term Disability Plan if you have an FTE status of 0.8 or more. Also, you must have one (1) year of continuous employment in an eligible class before you are covered by the plan.

What is my cost for the Long Term Disability Plan?

Parkview Health pays the full cost of your coverage under this plan. There is no cost to you.

What benefit will I receive if I am unable to work?

The amount of income you will receive from this Plan, if you qualify, will be based on your position and your pay. As in most LTD plans, the amount of income you receive will be reduced by any disability income from Social Security or Workers' Compensation. The maximum monthly benefit for regular, full-time co-workers is $5,000.

How long will my benefits continue if I am approved for Long Term Disability?

If you meet the definition of disability under this plan and The Hartford approves your claim, LTD payment will start after the 180-day elimination period. (Please note that elimination periods are different for job titles.) Your payments will continue until you are no longer disabled or, if earlier, when you reach the maximum payment period, which is age 65.

Life Insurance Plans

Most people don't like thinking about dying or being seriously injured. But it is important to plan for these "what if" situations in advance. Doing so helps ensure that your family will always have the income they will need to maintain their standard of living. All life insurance plans are provided and administered by The Hartford Insurance Company.

To make your "what if" planning easier, Parkview provides you with several forms of life insurance, which include:

- Basic Life and Accidental Death and Dismemberment (AD&D) insurance (insuring you). Parkview Health pays 100% of the cost of coverage.
- Supplemental Life Insurance is available to purchase additional coverage for yourself. You pay 100% of the cost.
- Dependent Life Insurance for your spouse and eligible dependent children is available for purchase. You pay 100% of the cost.
- Group Voluntary Accidental Death & Dismemberment Insurance is available for purchase for you and your family. You pay 100% of the cost.

What are the eligibility requirements for the Life Insurance Plans?

You are eligible for life insurance coverage if you have an FTE status of 0.6 or more. Dependents eligible for the Dependent Life for Spouse and Children as well as the Voluntary Accidental Death & Dismemberment Insurance coverage are:

- Your spouse
- Children under the age of 26

When are my Life Insurance Plans effective?

Your Basic Life and Accidental Death and Dismemberment (AD&D) Insurance that Parkview provides is effective on your date of hire.

If you enroll in Supplemental Life, Dependent Life for Spouse and Children and/or Accidental Death & Dismemberment Insurance within 31 days after hire, coverage will be effective the first day of the month following your date of hire. If you do not enroll within 31 days of becoming eligible, you will be required to submit evidence of insurability on yourself and your dependents if you elect Supplemental and/or Dependent Life Insurance. You may enroll in the Voluntary Accidental Death & Dismemberment Insurance or Dependent Life Child coverage at any time and without evidence of insurability. If you do not enroll within 31 days of becoming eligible, you may be required to submit evidence of insurability for yourself and your dependents if you elect Supplemental and/or Dependent Life Insurance.

How do I enroll for life insurance coverage?

To enroll for life insurance coverage, you will need to log into "MyHR" and elect coverage for yourself and dependents if applicable.

How do I name my life insurance beneficiaries?

You will need to name your beneficiary for Basic Life and AD&D Insurance. You may name your beneficiary at the time you enroll for coverage in MyHR. Your beneficiary is the person (or persons) who will receive your Basic and Supplemental Term Life Insurance benefits if you die. You can name anyone you want as your beneficiary(ies) – and designate as many people as beneficiary(ies) as you wish – for your Basic and Supplemental Term Life Insurance. You must specify the percentage of the benefit to be paid to each beneficiary (up to a maximum of 100% for all allocations). You are automatically the beneficiary for payment of any Dependent Spouse and Children Life Insurance and the Group Accidental Death & Dismemberment plans you elect. Any changes you want to make to your Life Insurance may be completed within MyHR. You may click here for more information on how to designate or change your beneficiary in MyHR.

➢ Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Basic Life and AD&D Insurance pays your beneficiary a lump-sum benefit in the event of your death while you are insured. If you die because of an accident, your estate or your beneficiary may receive an additional lump sum under the AD&D coverage.

The amount of this Basic Life insurance benefit depends on your employment status.

- If you are an FTE status of 0.8 to 1.0, your coverage will be 1 ½ times your base annual salary to a maximum of $200,000. You will also have AD&D coverage of another 1 ½ times your base annual salary to a maximum of $200,000.
- If your FTE status is a 0.6 to 0.7 FTE, your life insurance coverage will be $15,000 with AD&D of another $15,000.

Note: Under Section 79 of the Internal Revenue Code, Parkview Health is required to report the imputed cost of any employer-provided life insurance benefits that exceeds $50,000. The imputed cost is calculated using the IRS Premium Table. If you wish to avoid this additional taxable income, you may waive all life insurance above $50,000 by completing a Group Term Life Insurance Waiver of Entitlement form. You will need to contact Parkview Health's HR Benefits and Informatics Consultant for more information.

➢ Supplemental Life Insurance

Supplemental Life Insurance is available to you at group rates based on your age. It pays your beneficiary a lump-sum benefit in the event of your death while you are insured. This coverage is in addition to the Basic Life and/or AD&D benefit. Co-workers with an FTE status of 0.6 or more may elect coverage of one time, two times, or up to seven times their annual base salary, rounded up to the nearest thousand, to a maximum of $750,000.

What is the cost for Supplemental Life Insurance?

You pay 100% of the cost for Supplemental Life Insurance coverage. Premiums are deducted on the first paycheck of each month and are based upon your age. The cost for coverage is listed below.

Age	Monthly Cost Per $1,000 of Coverage for Supplemental Life	Age	Monthly Cost Per $1,000 of Coverage for Supplemental Life
Under 30	$0.048	50 – 54	$0.264
30 – 34	$0.048	55 – 59	$0.424
35 – 39	$0.056	60 – 64	$0.608
40 – 44	$0.088	65 – 69	$1.000
45 – 49	$0.160	70 +	$2.380

How do I enroll for Supplemental Life Insurance?

- **Enrollment during Initial Enrollment Period:**
  - You may enroll for Supplemental Life Insurance coverage within 31 days of your date of hire. Enrollment is done through "MyHR". If you elect Supplemental Life insurance coverage that exceeds four times your annual base salary, you will need to request a Statement of Health to be sent to you. Once completed, you will forward to the Hartford for their approval of coverage . To request a Statement of Health, please contact the HR Benefits and Informatics Consultant at 260-266-7276.

- **Enrollment outside of Initial Enrollment Period:**
  - You may apply for Supplemental Life Insurance at any time by contacting the HR Benefits and Informatics Consultant at 260-266-7276. You will need to complete a Statement of Health form if you are outside of the 31-day period following date of hire. Statement of Health forms are submitted to The Hartford for their approval of coverage.

➢ Dependent Life Insurance

Dependent Life Insurance is available for your spouse and dependent children. The cost of coverage is paid by you and based upon the amount of coverage elected. It pays you a lump-sum benefit in the event of your spouse or child's death while insured. Co-workers with an FTE status of 0.6 or more may elect coverage in the amounts listed below.

What coverage is available for my spouse?

The coverage options along with the monthly rates are below. Premiums are deducted on the first paycheck of each month.

Dependent Life – Spouse Plan	Coverage	Monthly Premium
Option 1:	$10,000	$2.30
Option 2:	$25,000	$5.75
Option 3:	$50,000	$11.50
Option 4:	$75,000	$17.25
Option 5:	$100,000	$23.00

What coverage is available for my dependent child(ren)?

The coverage options are listed below along with the monthly rates. Premiums are deducted on the first paycheck of each month. Your child(ren) under the age of 26 are eligible for coverage.

Dependent Child(ren) Plan	Coverage	Monthly Premium (Covers all eligible child(ren))
Option 1:	$5,000	$0.60
Option 2:	$10,000	$1.20

What is the definition of an eligible dependent child?

- Under age 26

How do I enroll for Dependent Life Insurance?

- Enrollment during Initial Enrollment Period:
  - You may enroll through "MyHR" in the Dependent Life for Spouse and/or Dependent Life for Children Plans within 31 days from your date of hire or qualified life status event.
  - You do not need to complete a Statement of Health for election of Dependent Life for Spouse Plan if you elect Option 1 or Option 2. If you elect Option 3, 4, or 5 for your spouse's coverage, you will need to request a Statement of Health for the additional coverage by contacting the HR Benefits and Informatics Consultant at 260-266-7276. You will send your completed form to The Hartford for their approval of coverage.
  - You do not need to complete a Statement of Health for election of Dependent Life for Children.

- Enrollment outside of Initial Enrollment Period:
  - You may apply for enrollment in the Dependent Life for Spouse and/or Children plans at any time by contacting the HR Benefits and Informatics Consultant at 260-266-7276. A Statement of Health form for your spouse will be sent to you. Your completed Statement of Health forms will be submitted to The Hartford for their approval. No Statement of Health is required for Child(ren) coverage.

➢ Voluntary Accidental Death & Dismemberment (AD&D)

Voluntary AD & D Insurance is available for you to purchase for yourself only or for you and your family. The cost of coverage is paid by you with premiums based on the amount of coverage elected. It pays a lump-sum benefit if you (or a family member whom you have elected to cover) die or loses an eye or limb within 365 days of an accident to which the death or loss is related. You will select coverage amounts in multiples of $10,000 with the maximum coverage amount of $300,000. Co-workers with an FTE status of 0.6 or more may elect coverage. Premium amounts are listed below.

What coverage and amounts are available for myself and my family?

You may elect coverage amounts in $10,000 increments up to the maximum amount of $300,000. The coverage payout for the co-worker is always the amount of coverage elected. Family coverage and benefit amount is shown below.

- If married with dependent children, coverage is:
  - Spouse - 50% of elected coverage amount
  - Child(ren) - 10% of elected coverage amount

- If married with no dependent children, coverage is:
  - Spouse - 60% of elected coverage amount

- If not married with dependent children, coverage is:
  - Child(ren) - 15% of elected coverage amount

Type of coverage available: ***(May select $10,000 increments up to a maximum of $300,000)***	***Monthly Cost Per $1,000 of Coverage***
Co-worker Only Coverage	$0.014
Co-worker + Spouse + Child(ren) Coverage	$0.022

How do I enroll for Accidental Death & Dismemberment Insurance?

- Enrollment during Initial Enrollment Period:
  - May enroll in the Accidental Death & Dismemberment plan through "MyHR" within 31 days from your date of hire. No Statement of Health will be necessary.

- Enrollment outside of Initial Enrollment Period:
  - May enroll in the Accidental Death & Dismember plan at any time by contacting the HR Benefits and Informatics Consultant at 260-266-7276. No Statement of Health will be necessary.

Are there other specific features that are included in the Basic and Supplemental Life Insurance plans?

The Hartford offers specific features to both their Basic and Supplemental Life Insurance Plans. This variety of added features may help you and family members today and during a challenging time. Some of those features include the following. If you are interested in more details, please refer to Human Resource's site on The Pulse for the Life Insurance Summary Plan Descriptions.

- Will Preparation
- Service Grief Counseling
- Portability
- Accelerated Benefits Option
- Advice for Beneficiaries
- Waiver of Premiums for Disability
- AD&D Coverage with Travel Assistance Services

Retirement Savings Plans

Parkview Health can help you build financial resources for a more secure and comfortable future through the retirement plans offered to all eligible co-workers. To achieve your goals for a successful, rewarding life after you retire, you will need to plan for a steady stream of retirement income.

Parkview Health provides eligible co-workers with a retirement savings that includes the plans listed below. The plans are intended to provide retirement income to supplement retirement payments received from other income sources such as personal savings, investments, and Social Security.

- 403(b) Plan
- Retirement Savings Plan
- 403(b) Match Plan

Who is the administrator for Parkview Health's retirement plans and how can I access my account balances?

Lincoln Financial Group is the administrator for all of Parkview Health's Retirement Plans. You may access information about your accounts at any time by the following two ways:

- Online - http://lfg.com; or
- Phone – Lincoln Financial Group Customer Service, 800-234-3500
- Site or Virtual appointment – Schedule a visit with a rep at: http://LincolnFinancial.com/ParkviewSchedule

What investment options are available for my retirement plans?

The Plan provides the opportunity to invest both your contributions as well as the contributions Parkview Health makes on your behalf. That means, you are responsible for designating the contributions, as well as any investment return from those contributions, in the investment fund options available.

Your account balance will be based on the fund performance of your investment choices and will fluctuate according to the financial market changes. You will be able to choose from a range of investment options offered through Lincoln Financial Group, ranging from low-risk, low-return to high-risk, high-return funds. You may create your own investment strategy for your account. You also may make changes to your investments at any time by accessing your account online. The Lincoln Alliance Program offers you a diverse list of investment funds. Also, you may use Lincoln's self-directed brokerage accounts for a minimal annual cost.

➢ 403(b) Plan

All co-workers are eligible to set aside their own earnings through salary deferral contributions to the 403(b) Plan upon their date of hire. You may elect either the pre-tax or after-tax salary deferrals.

How much may I contribute to the plan in 2023?

Your contributions are made through payroll deductions. You are always 100% vested in your contributions and the earnings they generate. You may contribute up to $22,500 in 2023 ($30,000 if you are 50 years of age or older) or 100% of your eligible annual compensation, whichever is less. You may increase, decrease or stop your salary deferral contributions at any time. You will make the change online or phone request with Lincoln Financial Group.

Are hardship withdrawals and loans available should I need money from my account?

Although the Parkview Health 403(b) Plan is intended to help you put aside money for the future, if you have an immediate financial need created by severe hardship and you have no other available resources to meet that need, you may be eligible to receive a hardship withdrawal from your 403(b) account. Also, you may have the option to borrow money through a loan from your 403(b) account.

For more information about the 403(b) Plan, click here for the Summary Plan Description.

➢ Retirement Contribution Plan

The Retirement Contribution Plan is a retirement savings plan in which Parkview Health makes contributions to an account on an annual basis for eligible co-workers. The benefit is expressed as an account balance and grows with Parkview Health contributions and investment returns on those contributions. Your Parkview Health contribution will increase as your years of benefit service increase.

What are the eligibility requirements to receive a contribution from this Plan?

You automatically enter the Retirement Contribution Plan and begin accruing benefit service on the first day of the month after you meet the following eligibility requirements:

- Employed or re-employed with Parkview Health on or after January 1, 2005,
- At least 21 years of age; and
- Completion of 1,000 hours of service within your first 12 months of employment or during any later calendar year.

What is the vesting schedule for the Retirement Contribution Plan?

You become 100% vested in your account after completing three (3) years of vesting service. You earn a year of vesting service for each calendar year in which you complete at least 1,000 hours of service. Once you are 100% vested, if you leave Parkview's employment, you will have access to this plan following your last day of work.

How much is Parkview Health's contribution to the Retirement Contribution Plan?

Your contribution is based upon the number of years of Benefit Service you accrue. You earn a year of benefit service for each calendar year that you complete at least 1,000 hours of service, starting when you reach age 21. The chart below provides the percent of contribution based upon the number of years of benefit service.

Years of Benefit Service	*Contribution Amount (Amount is limited to the annual IRS maximum amount.)*
Under 5 years of benefit service	2%
5 – 9 years of benefit service	4%
10 – 14 years of benefit service	6%
15 or more years of benefit service	8%

For more information about the Retirement Contribution Plan, click here for the Summary Plan Description.

➢ 403(b) Match Plan

You are eligible to receive matching contributions to your 403(b) deferrals once you complete two years of service with at least 1,000 hours in each year. You will enter the plan on the first day of the month after meeting the eligibility requirements. Matching contributions will be deposited into an account with Lincoln Financial Group.

How much is Parkview Health's contribution to the Match Plan?

Parkview Health will make a matching contribution to the plan in an amount equal to 50% of the first 2% of pay you contribute to your 403(b) Plan, plus 100% of the next 2% of pay that you contribute to your 403(b) Plan.

> Example: Assuming you earn $30,000 a year and you defer 4% of your pay to a 403(b) Plan, since 2% of $30,000 is $600, Parkview will match 50% of the first $600 you save in the 403(b) Plan that year, plus 100% of the next $600 you save. So, if you earn $30,000 a year and save 4% in your 403(b) Plan, Parkview will contribute $900 to your matching contribution account ($300 on the first 2% of pay you save plus $600 on the next 2% = $900)

You are always 100% vested in your contributions and the earnings they generate. For more information about the Match Plan, click here for the Summary Plan Description.

Volunteer Time Off

Parkview Health is proud to provide sixteen (16) hours of paid Volunteer Time Off (VTO) hours to all coworkers on an annual basis. Co-workers in any FTE status are encouraged to volunteer up to 16 hours per calendar year to support local schools and other non-profit organizations.

Volunteer Time Off must be pre-approved by your department leader and is subject to Parkview Health guidelines and departmental guidelines. Please refer to the Parkview policy as well as discuss with your leader as you plan to schedule this time. These (VTO) hours are paid by Parkview Health and are separate from the Paid Time Off Plan described in the following section.

Paid Time Off Plan

Parkview Health provides paid time off for days away from work for benefit-eligible co-workers. Paid Time Off is available for the purpose of rest, relaxation, illness, holidays, personal time or to care for dependents. For more information regarding this plan, please refer to the Paid Time Off Human Resources Policy.

The Paid Time Off (PTO) program puts vacation, sick leave, and holidays into one program. This provides you more flexibility in scheduling time off to meet family needs and balance work and personal life. The design of the PTO program is also intended to assist co-workers and Parkview Health in managing staffing needs to meet the operational needs.

How do I accrue PTO benefits?

You will accrue a set number of hours of PTO time each pay period. The number of hours you accrue will be based on your position, your FTE status and your length of service with Parkview. You begin accruing PTO time during the first pay period you work. Each bi-weekly pay period, you earn a PTO accrual based on the number of hours paid during the prior pay period up to a maximum of 80 work hours. Please see the following chart.

The maximum you may accrue in your PTO “bank” is 300 hours. PTO time is paid according to your work schedule at the current wage/salary rate, including shift differential. PTO time is not counted as hours worked for the purpose of determining eligibility for overtime.

Paid Time Off Accrual Amounts by Job Type and FTE

PTO ACCRUAL CHART		1.0 FTE Must work minimum of 80 hours.	0.9 FTE Must work minimum of 72 hours.	0.8 FTE Must work minimum of 64 hours.	0.7 FTE Must work minimum of 56 hours.	0.67 FTE Must work minimum of 48 hours.
PTO Plan & Length of Service:	PTO Earned Per Year	Hours Accrued (per pay period)	Hours Accrued (per pay period)	Hours Accrued (per pay period)	Hours Accrued (per pay period)	Hours Accrued (per pay period)
PTO Plan A						
0 - 5 years	23 days	7.1	6.4	5.7	3.3	2.8
6 - 9 years	28 days	8.7	7.8	6.9	4.3	3.7
10 - 24 years	33 days	10.2	9.1	8.1	5.4	4.6
25+ years (reached after 1/1/11)	34 days	10.5	9.4	8.4	5.6	4.8
PTO Plan B						
0 - 5 years	28 days	8.7	7.8	6.9	4.3	3.7
6 - 24 years	33 days	10.2	9.1	8.1	5.4	4.6
25+ years (reached after 1/1/11)	34 days	10.5	9.4	8.4	5.6	4.8
PTO Plan C						
0 - 2 years	28 days	8.7	7.8	6.9	4.3	3.7
3 – 24 years	33 days	10.2	9.1	8.1	5.4	4.6
25+ years (reached after 1/1/11)	34 days	10.5	9.4	8.4	5.6	4.8

Lifestyle Benefit

The Lifestyle Benefit program provides opportunity each quarter for benefit eligible co-workers to submit reimbursement requests for a variety of needs. Categories such as Food and Family are available to assist co-workers with basic needs while other categories, such as Treat Yourself, are available to allow co-workers the option to indulge in something more for themselves. Whatever your need in any quarter, the new Lifestyle benefit is designed to meet your changing needs.

Co-workers in a benefit eligible FTE status at the start of each quarter will be sent an email from our vendor partner, Compt, informing the coworker their lifestyle benefit is available for use. After submitting receipts for expenses incurred in a variety of spend categories, part-time co-workers may be reimbursed up to $500 per year, or $125 per quarter, and full-time co-workers may receive up to $1,000 per year, or $250 per quarter.

Co-workers are able to submit receipts for reimbursement under the following categories. Please refer to the Lifestyle Benefit Spend Categories document for examples of expenses for each category:

- Family
- Financial Wellness
- Food
- Health & Wellness
- Remote Work Office Equipment
- Treat Yourself

Watch your Parkview email for communications from Compt on your benefit availability.

Flexible Spending Accounts - FSA

Contributing money to a Healthcare and/or Dependent Care Flexible Spending Account is a way to stretch your dollars. The Parkflex Healthcare and/or Dependent Care FSA provides the opportunity to save on healthcare and dependent/elder care expenses using pre-tax dollars. Each paycheck, you set aside a portion of your pay, before taxes, to use for eligible expenses. This is a way to INCREASE your spendable income while lowering the amount of taxes you pay. Enrolling in one or both available accounts may accomplish this for you. HealthEquity is the administrator for the Parkflex plan. You may contact them at (877) 924-3967 for questions or more information. When deciding the amount you want to contribute, be careful to figure CONSERVATIVELY as you could forfeit any unused amounts. The Healthcare and Dependent Care Accounts are separate accounts. Funds cannot transfer from one account to the other.

How do Flexible Spending Accounts work?

Each paycheck, you set aside some of your pay, before taxes, to use for eligible expenses. This is how you save money: $100 put into your FSA is $100 to spend on eligible expenses. Without an FSA, you pay taxes, leaving $60 or $75 to pay for the same eligible expenses.

What are the 2023 Annual Plan Maximums?

- Healthcare Account Maximum Contribution $3,050
- Dependent Care Account Maximum Contribution $5,000

What is my Commitment Period for a Flexible Spending Account?

Beginning January 1, 2023, you are committed to remain in the plan for the entire plan year (January 1 through December 31). You may change your participation or contribution amounts if you have a change in status, such as marriage, divorce, death of spouse or dependent, birth or adoption of a child, change from part-time to full-time employment for you or your spouse, termination or commencement of spouse's employment, taking unpaid leave of absence by you or your spouse, dependent child enrolled in school, change in dependent care coverage, and change in cost of dependent care, except when a relative provides the service. You may be required to submit appropriate documentation to verify the event. When you have a status change that alters your coverage needs, you must contact your Human Resources office within 31 days of the qualifying event to make the change.

➢ Healthcare Flexible Spending Accounts

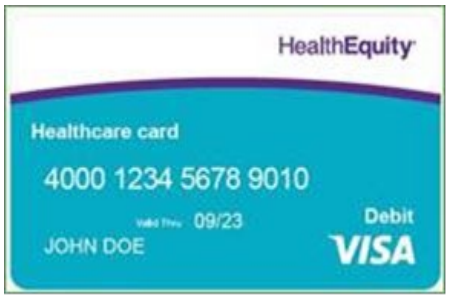
You may protect up to $3,050 of your pay from taxes by signing up for a Healthcare FSA. This account allows you to set aside money to pay for eligible health expenses such as co-pays, deductibles, and medical supplies. You will be provided with a HealthEquity health care card you can use to draw money from the account at the point of sale. Money set aside in a Healthcare FSA is not subject to federal or state taxes. That means an FSA can save you about $30-$40 on every $100 you spend on eligible expenses. The maximum allowable contribution for a Healthcare FSA is $3,050.

Contribution Limit	In 2023, you may contribute up to **$3,050** of your before-tax pay to the Healthcare FSA.
Carry Over Period and Forfeitures	FSA rules allow Parkview to offer a grace period at the end of 2023 for Healthcare FSA only. The grace period provides you with more time to use any 2023 remaining balance as of Dec. 31, 2023. This means you can continue to spend your 2023 unused funds until **Mar. 15, 2024**. Any unused amount after Mar. 15 will be forfeited.
Eligible Expenses*	▪ Deductibles, co-pays, co-insurance, prescriptions and Over-the-Counter Medicines ▪ Dental care and Orthodontia ▪ Visions exams, lens, frames, contacts, vision surgery ▪ Hearing aids and many other healthcare services and items **Click here* *to view the full list of eligible expenses*
Eligible Dependents	Eligible Dependents include any dependent you claim on your federal income tax return.
Last Day to File Claims	Any claims filed for 2023 expenses (incurred during 2023 and grace period for the Healthcare FSA ending Mar. 15, 2024) must be received (not postmarked) by HealthEquity on or before **May 31, 2024**, to qualify for payment out of your 2023 account.

How easy is using your Healthcare Flexible Spending Account?

When you elect the Healthcare FSA, your account is funded with the full amount you have chosen at the beginning of the year. As soon as that happens, it is ready to use for eligible expenses. Throughout the year, you "pay your account back" with pre-tax contributions from your paycheck. Use these convenient payment options:

- HealthEquity Healthcare Visa Card. Use it instead of cash at healthcare providers and wherever accepted for health-related services and health expenses.
- Pay My Provider. Send payment directly to your healthcare provider.
- Pay Me Back. File a claim online, by fax or mail for reimbursement.
- Mobile. Use your mobile application to file a claim from your smartphone.



Flexible Spending Account rules allow Parkview to offer a grace period at the end of the plan year for Healthcare FSA only. The grace period provides you with more time to use any 2023 remaining balance as of December 31, 2023. This means you can continue to spend your 2023 unused funds until March 15, 2024. Any unused amount after March 15 will be forfeited. All 2023 claims must be submitted by May 31, 2024. Any claims filed for 2023 expenses (incurred during the plan year and grace period for the Healthcare FSA ending on March 15, 2024) must be received (not postmarked) by HealthEquity on or before May 31, 2024) to qualify for payment out of your 2023 account.

May I continue my Healthcare Flexible Spending Account Through COBRA?

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Healthcare FSA and your employment with Parkview ends or are no longer eligible for the Plan, you may continue participation for the remainder of the Plan Year. If you want to remain in the Plan, you can do so by selecting COBRA continuation at the time you end employment. You may contact HPS at 260-266-5510 for more information.

➢ Dependent Care Flexible Spending Accounts

You can also choose a HealthEquity Dependent/Elder Care FSA to help with the cost of care for eligible children or aging parents while you are at work. A Dependent Care FSA works a lot like a healthcare FSA, but your account is funded each payroll period, so funds are available as contributions are taken from your paycheck.

Contribution Limit	In 2023, you may contribute up to **$5,000** of your before-tax pay to the Dependent Care FSA if you are married filing jointly, single or filing a return as head of household.
Carry Over Period and Forfeitures	There is no carry over provision in the Dependent Care FSA.
Eligible Expenses*	▪ Before-school and After-school day care expenses, preschool, and baby-sitting services (during your working hours) for your child up to their 13th birthday ▪ Day camp for your child up to their 13th birthday ▪ Household services for the care of an eligible elderly or disabled dependent who lives with you ▪ Expenses at an adult day care facility for an eligible elderly or disabled dependent who lives with you **Click here* *to view the full list of eligible expenses*
Eligible Dependents	You may use your FSA only for children **under age 13** or for older children and adults only if they are physically or mentally incapable of self-care.
Last Day to File Claims	Any claims filed for expenses incurred in 2023 expenses must be received (not postmarked) by HealthEquity on or before **Mar. 31, 2024**, to qualify for payment out of your 2023 account.

Voluntary Benefit Plans

➢ Critical Illness Coverage

Critical Illness coverage supplements the benefits of traditional medical coverage and helps with the financial needs of certain covered conditions. Critical Illness coverage complements existing medical coverage and helps to fill financial gaps caused by out-of-pocket expenses. Benefits are paid regardless of what is covered by medical insurance. Payments are made in a lump sum and sent directly to you to spend the benefits as you choose. MetLife administers Critical Illness Insurance. You may contact MetLife directly at 1-800-438-6388 (1-800-GET-MET8) for questions.

What are the conditions covered by the Critical Illness Plan?

Some of the conditions covered under the Critical Illness Plan typically include:

- Heart attack
- Stroke
- Alzheimer's Disease
- Certain cancers
- Kidney failure
- Major organ transplant

Am I eligible for coverage?

Parkview Health offers co-workers with an FTE of 0.6 or more the option to purchase Critical Illness Insurance.

What coverage is available and can I cover my spouse and dependent children?

Critical Illness coverage is provided in the amount of either $15,000 or $30,000 for you only or you and your eligible family members. You can purchase coverage for your spouse and dependent children. This coverage provides a lump sum payment to you upon the first diagnosis of a Covered Condition. You will enroll for this coverage through "MyHR". Coverage options are as follows:

Eligible Individual	Initial Benefit	Requirements
Co-worker	$15,000 or $30,000	Coverage is guaranteed provided you are actively at work.
Spouse	50% of the co-worker's Initial Benefit	Coverage is guaranteed provided you are actively at work and your spouse is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.
Dependent Child(ren)	50% of the co-worker's initial Benefit	Coverage is guaranteed provided you are actively at work and your dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.

For more information about Critical Illness Insurance coverage and to view a video, please click here.

Critical Illness Coverage Plan Cost

Coverage Amount • **$15,000 and** • **$30,000**	**Monthly Premium Amount per $1,000 of Coverage**			
Attained Age	Co-worker Only	Co-worker + Spouse	Co-worker + Dependent Child(ren)	Family
< 25	$0.22	$0.37	$0.40	$0.55
25 – 29	$0.24	$0.41	$0.42	$0.59
30 – 34	$0.33	$0.57	$0.52	$0.75
35 – 39	$0.47	$0.81	$0.65	$0.99
40 – 44	$0.72	$1.21	$0.90	$1.40
45 – 49	$1.07	$1.81	$1.25	$2.00
50 – 54	$1.51	$2.60	$1.69	$2.79
55 - 59	$2.07	$3.65	$2.25	$3.83
60 - 65	$2.97	$5.31	$3.15	$5.49
65-69	$4.45	$7.95	$4.63	$8.13
70+	$6.96	$12.05	$7.14	$12.24

Examples of Cost Calculation:

- Scenario 1 – Co-worker is age 29 and elects $30,000 of family coverage. According to the chart above, her cost per $1,000 of coverage under the family plan is $0.59. Multiple $0.59 X 30 = $17.70 per month.
- Scenario 2 – Co-worker is age 43 and elects $15,000 co-worker only coverage. According to the chart above, his cost per $1,000 of coverage under co-worker only plan is $0.72. Multiple $0.72 X 15 = $10.80 per month.

➢ Accident Insurance Coverage

The Accident Insurance plan provides you with a lump-sum payment following an accident to use as you see fit. It can help with out-of-pocket expenses such as deductibles, copays, transportation to medical centers, childcare and more. Benefits are paid regardless of what is covered by medical insurance. Payments are made in a lump sum and sent directly to you to spend the benefits as you choose. MetLife administers Accident Insurance. You may contact MetLife directly at 1-800-438-6388 (1-800-GET-MET8) for questions.

Parkview Health offers co-workers with an FTE of 0.6 or more the opportunity to purchase Accident Insurance coverage either for themselves or their spouse and dependent child(ren). You will enroll for this coverage through "MyHR". Coverage options are as follows:

Accident insurance includes benefits for:

- **Injuries**: fractures, dislocations, concussions, lacerations, eye injuries, torn knee cartilage, ruptured discs, second and third-degree burns
- **Medical services and treatments**: ambulance, emergency care, therapy services, medical testing (including x-rays, MRIs, CT scans), medical appliances and certain types of surgery
- **Hospitalization**: hospital admission, confinement and inpatient rehab after an accident[2]
- **Additional benefits**: accidental death, dismemberment, loss and paralysis; supplemental benefit for lodging
- **Additional coverage:** Coverage is available for your spouse and dependent children up to age 26.
- **Plus**: guaranteed acceptance, convenient payroll deduction, no coordination with other insurance benefits.
    - Portable coverage at the time you leave Parkview Health.

Accident Insurance Coverage Plan Cost

Coverage Options	Monthly Cost
Co-worker Only	$ 6.65
Co-worker and Spouse	$ 12.94
Co-worker and Child(ren)	$ 13.61
Family	$17.07

For more information about Accident Insurance coverage and to view a video, please click here.

➢ AFLAC Insurance Coverage

Parkview Health offers eligible co-workers the opportunity to purchase AFLAC insurance products through payroll deduction. AFLAC benefits are paid directly to you regardless of any other benefits you may have. You pay 100% of the cost.

Am I eligible for coverage?

Co-workers with an FTE of 0.6 or more can purchase AFLAC insurance plans.

What coverage is available?

AFLAC offers a full range of policies including:

- Short Term Disability – This plan benefit is independent of Parkview Health's Short Term Disability Plan. It provides you with a cash benefit each day you are disabled and is subject to your elimination and benefit period.
- Cancer Plan – This plan pays benefits to help with unexpected expense if cancer occurs. It covers treatments, surgery, hospitalization and more.
- Hospital Confinement Plan – This plan provides benefits due to a hospital confinement, rehab facility, hospital ER, short stay and more.

Where can I get more information about the coverages provided?

For more information about the coverages, contact Josh Hittler at 260-358-8157 or josh@krishittlerinsurance.com.

➢ Home and Auto Insurance Coverage

Parkview Health offers eligible co-workers the opportunity to purchase discounted group home and auto insurance coverage through payroll deduction. Upon inquiry, you will be presented no-cost, no-commitment quotes from multiple different insurance carriers to determine the best fit for your needs. You pay 100% of the cost via payroll deduction.

Am I eligible for coverage?

Co-workers with an FTE of 0.6 or more can purchase Group Homeowners and Auto Coverage.

What coverage is available?

These insurance providers offer a full range of policies:

- Home
- Renters
- Condominium
- Mobile Home
- Auto
- Boat
- Motorcycle
- Recreational Vehicle
- Landlord Rental Dwelling
- Personal Excess Liability ("Umbrella")

Where can I get more information about the coverages provided?

To find out more information about the coverages available please call Mercer at 855-275-5217 or visit their online portal at http://parkviewhealthvoluntarybenefits.com.

➢ Pet Insurance

Parkview Health offers eligible co-workers the opportunity to purchase pet insurance through payroll deduction. The coverage is provided through Nationwide. You pay 100% of the cost via payroll deduction.

Am I eligible for coverage?

Co-workers with an FTE of 0.6 or more can purchase Pet Insurance.

What coverage is available?

Nationwide offers two plans to best fit your needs. There is a My Pet Protection plan and a My Pet Protection with Wellness plan. Pet Insurance helps with pet medical bills, treatments, surgeries, lab fees, X-rays, prescriptions, and more

Where can I get more information about the coverages provided?

To find out more information about the coverages available please call Mercer at 855-275-5217 or visit their online portal at http://parkviewhealthvoluntarybenefits.com

➢ Identity Theft Protection

Parkview Health offers eligible co-workers the opportunity to purchase Identity Theft Protection through payroll deduction. The coverage is provided through AllState and provides credit monitoring to alert you at the first sign of fraud. You pay 100% of the cost via payroll deduction.

Am I eligible for coverage?

Co-workers with an FTE of 0.6 or more can purchase Identity Theft Protection.

What coverage is available?

Coverage is available either per employee for $7.95 per month or per family at $13.95 per month

Where can I get more information about the coverages provided?

To find out more information about the coverages available please call Mercer at 855-275-5217 or visit their online portal at http://parkviewhealthvoluntarybenefits.com

➢ Purchasing Power

Purchasing Power helps you purchase computers, appliances, electronics, furniture and more when paying with cash or credit is challenging. This program allows you to receive your product upfront and then pay over six or twelve months directly from your paycheck.

Am I eligible to participate?

Co-workers with one year of service in an FTE of 0.6 or more and meet the age and salary requirements are eligible to participate in this program.

Where can I get more information about this program?

To find out more information about the products available please call Purchasing Power at 888-923-6236 or visit their online portal at http://parkview.purchasingpower.com.

➢ SmartDollar

SmartDollar is a proven financial wellness program providing the practical steps, tools and inspiration you need to reach your money management goals. Bestselling authors and financial experts Dave Ramsey and Rachel Cruze bring personal finance to life with their engaging video lessons available 24/7 – along with the 7 Baby Steps plan, budgeting app, savings tracker and other helpful resources.

Am I eligible for coverage?

All co-workers in any FTE are eligible for this program.

What is the cost of this program?

Parkview Health is pleased to provide this program free of charge to all active co-workers.

How do I participate in this program?

To enroll please visit http://smartdollar.com/enroll/parkviewhealth

Benefits enrollment

How Do I enroll?

You have the opportunity to enroll in benefits (based on your employment status) using the online application "MyHR". You will be able to indicate your elections/dependents in Parkview Health's Medical, Dental and Vision plans, Voluntary Life insurance programs, Flexible Spending Healthcare and Dependent Care Programs and the Critical Illness and Accident Coverage Plans.

You may enter your benefit enrollments within 31 days from your date of hire/rehire/acquisition/change in status to a benefit-eligible position. However, we strongly encourage you to complete your enrollment as soon as possible so that your participation in time-sensitive plans such as Medical, Dental, and Vision is not delayed.

You may also update personal data such as name, home address, phone numbers, email addresses and more using "MyHR" any time during your employment with Parkview Health.

To get started with your enrollment, please review the following information.

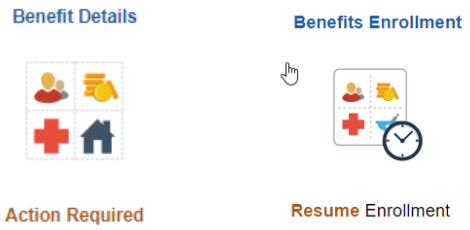
Accessing MyHR

- Go to http://myhr.parkview.com using Google Chrome or Microsoft Edge
- You have easy access to MyHR by using the same password as your network login. Your employee id and password used to login to the network will also be used to login to MyHR.
- If you are accessing outside of the Parkview network, an additional security step referred to as DUO is required for login. Information on this process can be found here.

Enrolling in Benefits

Provided you are eligible for benefits, use the Quick Guide to Benefit Enrollments for assistance with your enrollment. Additional information on MyHR and enrollment may be found on the Pulse here

Select the Benefit Details tile then the Benefits Enrollment tile, as shown below, and then you may begin your enrollment. Read the detailed instructions on each page and watch your progress on the lefthand side.



Spousal Attestation

If you are enrolling your spouse into the medical plan, part of the enrollment process is a required attestation. You will be asked to confirm your spouse's eligibility for medical coverage under the Working Spouse Rule as part of the enrollment process in MyHR. See page 7 or speak to human resources if you have additional questions about your spouse's eligibility for medical insurance coverage.

Beneficiary Designations

If you wish to add or update your life insurance beneficiaries during your employment with Parkview Health, you may log into MyHR, select Benefits Detail, and then the Benefits Summary tile. Click on the Life Insurance tile and add your beneficiary or update the beneficiary designation. Please contact your HR office should you have any questions.

Here to Serve You

Parkview Health Human Resources

Your Parkview Health Human Resources team is ready to answer your questions. Please contact the HR representative assigned to your facility.

Parkview Health Benefits and Informatics Department

HR Benefits and Informatics Team (260) 266-7276
Jessica Hunter, Supervisor Benefits & Inform (260) 266-2994
Gretchen Laws, Manager Benefits Admin (260) 266-4764
Ann Stevens, Corporate Total Rewards Director (260) 266-7275

Parkview Corporate Office & System Departments

Kacie Pulfer, HR Consultant (260) 266-3419

Parkview Hospital Randallia & Parkview Behavioral Health

Mandy Pavlidis, HR Consultant (260) 373-7313

Parkview DeKalb Hospital

Abby Mann, HR Consultant (260) 920-2805

Parkview Huntington Hospital

Angie Gutmann, HR Consultant (260) 569-2275

Parkview Noble & LaGrange Hospital

Meredith Sievers, HR Consultant (260) 347-8520

Parkview Whitley Hospital and Warsaw Medical Complex

Kim Harris, HR Consultant (260) 248-9376

Parkview Park Center

Kimberly Shininger, HR Consultant (260) 482-9125

Parkview Physicians Group

Janet Stutzman, HR Consultant (260) 266-6267
Carrie Isley, HR Consultant (260) 266-6268
Holly Geren, HR Consultant (419) 633-5479

Parkview Regional Medical Center and Ortho Hospital

Sarah Parrish, HR Consultant (260) 266-1051
Julie Sheehan, HR Consultant (260) 266-1056

Parkview Wabash Hospital

JoAnne Tribbett, HR Consultant (260) 569-2275

Questions for Signature Care? (260) 266-5510
For Prior Authorization (800) 666-6668
Questions for Delta Dental? (800) 524-0149
Questions for MetLife's Vision Plan? 1-855-MET-EYE1 (1-855-638-3931)

Appendix

Appendix 1

Parkview Health Medical Plans

Summary of Benefit Coverage
for
Signature Care and Anthem Plans

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about coverage, or to get a copy of the complete terms of coverage, go to Parkviewhealth.sharepoint.com > HR (found in Departments Quick Links) > Total Rewards > Benefits > Medical, Dental & Vision > Reference Materials > Medical Summary Plan Description or by calling 1-800-666-4449 option 1 or (260) 266-5510. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-666-4449, option 1 or (260) 266-5510 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Benefit Tier: Individual/Family Special Access: $625/$1,250 Network: $2,000/$4,000 Non-Network: $4,000/$8,000 Copayments, certain coinsurance, prescription drugs, premiums, balance-billed charges, and healthcare expenses this plan does not cover do not count toward the deductible.	Generally, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1). See the schedule of benefits in your plan document for how much you pay for covered services after you meet the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, certain office visits, certain prescriptions drugs, emergency room, and urgent care.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-carebenefits.
Are there other deductibles for specific services?	No.	This plan does not have service specific deductibles.
What is the out-of-pocket limit for this plan?	Benefit Tier: Individual/Family Special Access: $3,500/$7,000 Network: $7,900/$15,800 Non-Network: unlimited	The out–of–pocket limit is the most you could pay in a coverage period for covered services in both Network benefit tiers. There is no out–of–pocket limit for the non-Network benefit tier. Prescriptions covered under the pharmacy benefit accumulate to the Network out–of–pocket limit. If you have other family members in this plan, they have to meet their own out–of–pocket limit until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Brand/Generic Copay differential when requested by member, penalties for failure to obtain pre-authorization of services, and healthcare expenses this plan does	Even though you pay these expenses, they do not count toward the out–of–pocket limit.

	not cover.	
Will you pay less if you use a network provider?	Yes. It uses the Signature Care Network of Providers. For a list of Special Access and Network providers, see www.ParkviewTotalHealth.com or call 1-800-666-4449 or (260) 266-5510.	You pay the least if you use a provider in the Special Access Network. You pay more if you use a provider in the Signature Care Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays, if anything (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Special Access or Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Special Access: Office: $20 copay/visit Clinic: 20% coinsurance Network: Office: $35 copay/visit Clinic: 20% coinsurance	60% coinsurance	No coverage for use of a non-Network facility/facility-based clinic in the 13-county Parkview Service Area, but exclusion doesn't apply to separately billed charges by physicians/practice groups while receiving care in a facility or facility-based clinic.
	Specialist visit	Special Access: Office: $30 copay/visit Clinic: 20% coinsurance Network: Office: $45 copay/visit Clinic: 20% coinsurance	60% coinsurance	No coverage for use of a non-Network facility/facility-based clinic in the 13-county Parkview Service Area, but exclusion doesn't apply to separately billed charges by physicians/practice groups while receiving care in a facility/ facility-based clinic. For chiropractic care, services subject to plan's payment of $15/visit limit; max.24 visits/coverage period.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Special Access or Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preventive care/screening/immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	60% coinsurance	No coverage for use of a non-Network facility in 13-county Parkview Service Area.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	60% coinsurance	No coverage for use of a non-Network facility in 13-county Parkview Service Area.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.maxorplus.com Certain drugs may not	Generic drugs (Tier 1)	Special Access/Network: $10 / $30 copay prescription	No coverage	For generic, preferred brand, and non-preferred brand drugs, covers up to a 30-day supply; 31-60-day supply is two copays; and 61-90-day supply is 3 copays. A formulary is a list of drugs showing the generic, preferred brand, and non-preferred brand status, which determines copay amounts. http://parkview.maxorplus.com/
	Preferred brand drugs (Tier 2)	Special Access/Network: $30 / $60 copay prescription	No coverage	
	Non-preferred brand drugs (Tier 3)	Special Access/Network: $50 / $85 copay prescription	No coverage	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Special Access or Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
be covered under the Rx drug plan. Drugs may have certain quantity limitations or prior authorization requirements; for such requirements, see http://parkview.maxorplus.com/	Specialty drugs (Tiers 4 and 5) List of Specialty medications and applicable copays at http://parkview.maxorplus.com/.	Special Access/Network: $150 for preferred drugs (Tier 4) and $175 for non-preferred drugs (Tier 5). Covers up to a 30-day supply of specialty drugs.	No coverage	Brand/Generic Copay Differential applies if the patient or doctor requests a brand drug when a generic equivalent exists. You will pay the brand copay plus the cost difference between the brand and generic drug. Refills require 75% usage of the current supply before allowed to fill. Prescriptions from non-Network pharmacies are covered only in emergency situations. You will need to pay the full drug cost, and then submit a paper claim along with the receipt for reimbursement. The paper claim form can be found at www.maxorplus.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	60% coinsurance	Non-Network outpatient surgery requires prior authorization; no coverage for use of a non-Network facility in the 13-county Parkview Service Area.
	Physician/surgeon fees	20% coinsurance	60% coinsurance	Non-Network outpatient surgery requires prior authorization; certain non-Network ancillary charges incurred while outpatient at a Network facility will be paid at the Network benefit level as required by law.
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	————————None————————
	Emergency medical transportation	20% coinsurance	20% coinsurance	Prior authorization required for air transport between facilities (failure results in no coverage) unless in an emergency.
	Urgent care	$75 copay/visit	$75 copay/visit	————————None————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Special Access or Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	60% coinsurance	Requires prior authorization for inpatient and observation stays (except for hospital stays fewer than 48 hours following an uncomplicated vaginal delivery or stays of fewer than 96 hours following a cesarean delivery); no non-Network facility coverage in the Parkview service area; certain non-Network ancillary charges incurred while outpatient at a Network facility will be paid at the Network benefit level.
	Physician/surgeon fee	20% coinsurance	60% coinsurance	Non-Network anesthesia, radiology, and pathology charges incurred while outpatient at a Network facility will be paid at the Network benefit level
If you need mental health, behavioral health, or substance abuse services	Professional and Outpatient services	Special Access: $20 copay/office visit; 20% coinsurance all other Network: $35 copay/office visit; 20% coinsurance all other	60% coinsurance	
	Inpatient services	20% coinsurance	60% coinsurance	
If you are pregnant	Office Visits	$0	60% coinsurance	Cost sharing does not apply for preventive services. 2 ultrasounds and 1 fetal biophysical profile are allowed, but any additional require prior authorization; all ultrasounds and biophysical profiles apply to deductible/coinsurance; no non-Network facility coverage in 13-county Parkview Service Area
	Childbirth/delivery professional services	$0	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Special Access or Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Delivery and all inpatient services	20% coinsurance	60% coinsurance	Prior authorization required for inpatient stays longer than 48 hours (vaginal delivery)/96 hours (Cesarean delivery).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	60% coinsurance	Prior authorization required; max. 60 visits/year; custodial care not covered.
	Rehabilitation services	20% coinsurance	60% coinsurance	Max. 30 days per therapy, per-year; no non-Network facility coverage in 13-county Parkview Service Area.
	Habilitation services	20% coinsurance	60% coinsurance	Prior authorization required for ABA Therapy. Max. 30 days per therapy per plan year; no non-Network facility coverage in the 13-county Parkview Service Area.
	Skilled nursing care	20% coinsurance	60% coinsurance	Prior authorization required; max. 60 visits/year; custodial care not covered; no non-Network facility coverage in 13-county Parkview Service Area.
	Durable medical equipment	20% coinsurance	60% coinsurance	Prior authorization required for purchases of $1,000 or more or for all rentals, repairs, replacements or convenience items (except nebulizers).
	Hospice service	20% coinsurance	60% coinsurance	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery unless medically necessary to restore bodily function, to correct a deformity, or in conjunction with a mastectomy as legally required.
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Certain hazardous activities
- Elective abortions unless due to rape, incest or mother's life is endangered.
- Dental or eye care
- Private duty nursing unless medically necessary
- Routine eye care (adult)
- Routine foot care unless medically necessary
- Weight loss programs

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

- Chiropractic care limited to a $15 plan payment for up to 24 visits per plan year
- Dental care (adult) only for treatment of sound, natural teeth made necessary as a result of an acute injury
- Hearing aids up to $1,000 every three plan years
- Infertility treatment up to $2,000 lifetime maximum

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration, at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: by phone (260) 266-5510 or (800) 666-4449 or write Attn: Benefit Advocate, Parkview Health Plan Services, PO Box 5548, Fort Wayne, IN 46895-5548 and the Department of Labor's Employee Benefits Security Administration, at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (260) 266-5397.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (260) 266-5397.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (260) 266-5397.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (260) 266-5397.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility)	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$28,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$80
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,330**

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

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$1,291**
Total Example Cost	**$2,627**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$280
Copayments	$267
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$547**

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

The plan's overall deductible	$2,000
Specialist	$40
Hospital (facility) *[cost sharing]*	20%
Other coinsurance	20%

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

The plan would be responsible for the other costs o of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://eoc.anthem.com/eocdps/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/or call (833)578-4441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000/person or $6,000/family for In-Network Providers. $6,000/person or $18,000/family for Non- Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of- pocket limit for this plan?	$3,500/person or $10,500/family for In-Network Providers. $10,500/person or $31,500/family for Non- Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Blue Access. See www.anthem.com or call for a list of network providers. Costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Same as In- Network	$25/visit deductible does not apply	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	Same as In- Network	$50/visit deductible does not apply	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	Same as In- Network	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Same as In- Network	No charge	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	Same as In- Network	20% coinsurance	50% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacy information/	Tier 1 - Typically Generic	$10/prescription, deductible does not apply (retail) and $25/prescription, deductible does not apply (home delivery)	$20/prescription, deductible does not apply (retail only)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	For more information, refer to "Essential Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$35/prescription, deductible does not apply (retail) and $105/prescription, deductible does not apply (home delivery)	$45/prescription, deductible does not apply (retail only)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$75/prescription, deductible does not apply	$85/prescription, deductible does not apply	50% coinsurance, deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
		apply (retail) and $225/prescription, deductible does not apply (home delivery)	apply (retail only)	apply (retail) and Not covered (home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	25% coinsurance up to $350/prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450/prescription, deductible does not apply (retail only)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as In- Network	20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	Same as In- Network	20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	Same as In- Network	$250/visit then 20% coinsurance deductible does not apply	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	Same as In- Network	20% coinsurance	Covered as In- Network	Non-emergency non-network Ambulance Services are limited to $50,000 per trip.
	Urgent care	Same as In- Network	$75/visit deductible does not apply	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as In- Network	20% coinsurance	50% coinsurance	150 days/benefit period for In-patient physical medicine, re-habilitation including day re-habilitation programs and skilled nursing services combined for In-Network and Non-Network Providers combined.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	Same as In- Network	20% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as In- Network	Office Visit $25/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	Same as In-Network	20% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	Same as In- Network	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Same as In-Network	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	Same as In-Network	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Same as In-Network	20% coinsurance	50% coinsurance	120 visits/benefit period for Home Health and Private Duty Nursing combined for In- Network and Non-Network Providers combined.
	Rehabilitation services	Same as In-Network	$50/visit deductible does not apply	50% coinsurance	*See Therapy Services section.
	Habilitation services	Same as In-Network	$50/visit deductible does not apply	50% coinsurance	
	Skilled nursing care	Same as In-Network	20% coinsurance	50% coinsurance	150 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined for In-Network and Non-Network Providers combined.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	Same as In-Network	20% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	Same as In-Network	No charge	No charge	--------none--------
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	$0 copayment up to plan's Maximum Allowed Amount	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Dental care (Adult)
- Glasses for a child
- Long-term care
- Bariatric surgery
- Dental care (Pediatric)
- Hearing aids
- Routine foot care unless medically necessary
- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs

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

- Chiropractic care 12 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 120 visits/benefit period combined with Home Health

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform
State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual Care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,880**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4441。

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'idíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehǰí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koǰí' hodíilnih (833) 578-4441.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4441.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wicca nag walang bayad. Makipag-usap say isang tagapagpaliwanag, tawagan ang (833) 578-4441.

It's important we treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368- 1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Dental Plan

Appendix 2

Delta Dental is the provider for Parkview Health's dental plan. The level of dental benefits you receive depends on the provider you choose to use, Delta Dental PPO, Delta Dental Premier, or Non-Network. There will be no benefit plan design changes or increase in co-worker contributions for 2023. For additional information, please refer to the Delta Dental information by clicking here.

Annual Deductible	PPO	Premier	Non-Network Provider
Single	$25	$25	$50
Family	$75	$75	$150
Benefit Maximums			
Orthodontia	$1,500 per lifetime	$1,500 per lifetime	$1,500 per lifetime
Basic, Minor, and Major Restorative Services (excludes exams, fluoride, sealants, prophylaxes (cleanings), x-rays, brush biopsy, and orthodontic services)	$1,500 per person per year	$1,500 per person per year	$1,500 per person per year
Preventive Services	**No Deductible Applies**		
Oral exams (two per calendar year) Bitewing x-rays (up to one set per calendar year) Full mouth x-ray or Panoramic X-ray (once every five years) Prophylaxis cleaning and polishing (two per calendar year) Fluoride treatments for children up to age 19 (two per calendar year) Periapical x-rays	Plan pays 100%	Plan pays 100%	Plan pays 80%
Basic and Minor Restorative Services	**Subject to Deductible**		
Fillings, relines and repairs to bridges, dentures and partials Simple Extractions Perio Maintenance (two per calendar year) Non-surgical Perio	Plan pays 90%	Plan pays 80%	Plan pays 70%
Major Restorative Services	**Subject to Deductible**		
Oral surgery Surgical Periodontics Root canal therapy (Endodontics) Fixed and removable bridges and implants (once every 5 years) Inlays and crowns when not part of a bridge (once every 5 years) Full and partial dentures (once every 5 yrs.)	Plan pays 70%	Plan pays 60%	Plan pays 50%
Sealants	**No Deductible Applies**		
Payable once per tooth per lifetime for first permanent molars up to age 8 and second permanent molars up to age 13	Plan pays 100%	Plan pays 80%	Plan pays 50%
Orthodontia	**No Deductible Applies**		
Orthodontia is covered through age 18 (prior to 19th birthday)	Plan pays 60%	Plan pays 60%	Plan pays 50%

Vision Plan

Appendix 3

MetLife is the provider for the Parkview Health Vision Plan. MetLife offers a nationwide vision care plan to manage the costs of eyeglasses and contact lenses, as well as eye examinations. You do not need to be enrolled in Parkview's medical or dental plan to participate in the Vision Plan.

The vision care plan provides coverage for prescription lenses and frames, contact lenses (in lieu of eyeglasses), and a complete annual eye exam for a low monthly premium. Under the plan, you can visit an optometrist or ophthalmologist within the MetLife Vision network, or you may choose to visit an out-of-network provider, which may result in higher out-of-pocket costs. If you visit an out-of-network provider, you must submit a claim for reimbursement.

The vision plan covers:

- One vision exam every 12 months
- Eyeglass lenses or contacts once every 12 months
- Frames once every 24 months

Highlights of the Vision Plan are indicated below. The Vision Benefit Plan Summary is available online. To view MetLife vision providers, you may visit www.metlife.com and click on "Find a Vision Provider" or call MetLife Vision at (855) MET-EYE1 (855-638-3931) for access to the 24/7 Interactive Voice Response system. Once you enroll in vision and after January 1, 2023 (for new enrollees), you may view your vision benefits at www.mybenefits.metlife.com.

Vision Plan Highlights

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision provider and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[1]

Savings on glasses and sunglasses:Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.[1]

Laser vision correction: [2] Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam • Eye health exam, dilation, prescription and refraction for glasses: Covered in full • Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice.	Once every **12** months
Frame Allowance: **$80** • Costco, Walmart and Sam's Club: **$45** allowance You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.	Once every **24** months
Standard corrective lenses • Single vision, lined bifocal, lined trifocal, lenticular: Covered in full	Once every **12** months
Standard lens enhancements[1] • Standard Polycarbonate (child up to age 18), **and Ultraviolet (UV) coating:** Covered in full • Progressive Standard, Standard Polycarbonate (adult), Scratch-resistant coatings, Tints, Anti-reflective, Photochromic: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at metlife.com/mybenefits.	Once every **12 m**onths
Contact lenses (instead of eyeglasses) • Contact fitting and evaluation: Copay not to exceed **$60** • Elective lenses: $100 allowance • Necessary lenses: Covered in full after eyewear copay.	Once every **12 m**onths

We're here to help

Find a Vision provider at www.metlife.com/vision
Download a claim form at www.metlife.com/mybenefits
For general questions, go to www.metlife.com/mybenefits;
Or call 1-855-MET-EYE1 (1-855-638-3931)

Out-of-Network Reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **in-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

- Eye exam: up to **$45**
- Frames: up to **$45**
- Single-vision lenses: up to **$45**
- Lined bifocal lenses: up to **$85**
- Lenticular lenses: up to **$125**
- Contact lenses:
  - Elective up to **$80**
  - Necessary up to **$210**
- Lined trifocal lenses: up to **$85**
- Progressive lenses: up to **$65**

Other Important Information

Regulatory Notices for Plan Participants

Parkview Health is required to provide you with notices about your rights and responsibilities related to healthcare coverage. The information is included on the Total Rewards Pulse Page and you may access the full text of each notice by clicking here. A summary of each is provided below.

ACA Health Insurance Marketplace

Basic information about the ACA Health Insurance Marketplace and health coverage offered by Parkview Health which meets the affordability and minimum value standards defined by ACA.

COBRA

Learn about the temporary extension of certain benefits (such as medical and dental coverage) at group rates if you or your dependents lose coverage.

Creditable Coverage Notice

Notice of Parkview Health's creditable coverage status as related to Medicare and prescription drug coverage.

EEOC Notice Regarding Wellness Program

Notice that Parkview Heath MyWell-Being program is a voluntary wellness program available to all co-workers and eligible spouses. You are not required to complete the HRA or participate in other program requirements.

HIPAA Notice of Reasonable Alternative Standards (for Health-Contingent Wellness Programs)

Notice that provides information about alternatives for qualifying for the same credit under the MyWell-Bing Program.

Newborns and Mother's Health Protection Act

Under Federal Law, group health plans cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

Notice of Special Enrollment Rights for Medical Plan Coverage

Parkview Health plan participants may change health coverage during the year when they experience specified changes in status and there is immediate notification to the employers. This notice contains guidelines for these changes and notification parameters.

Parkview Health HIPAA Privacy Notice

Notice that Parkview Health maintains the privacy of Protected Health Information (PHI) that is received or created by its healthcare plans.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from Parkview, the State of Indiana or your home state may have a premium assistance program that can help pay for coverage.

Women's Health and Cancer Rights Act Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, Parkview Health provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call Signature Care at (260) 266-5510 or Anthem at (833) 578-4441 more information.

➢ Glossary of Terms

The Glossary of Terms provided below may be helpful as you review the information in this booklet.

Coinsurance

Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an outpatient service is $100 and you have met your deductible, your co-insurance payment of 20% will be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment (copay)

A fixed amount (for example, $25) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible

The amount you owe for healthcare services covered by your health insurance plan before your health insurance or plan begins to pay. For example, if your deductible is $2,000, you must meet your $2,000 deductible before the plan will pay for covered healthcare services subject to the deductible. The deductible may not apply to all services. You must pay a new deductible each year; there is no carryover from one year to the next.

Fee schedule

The amount the plan determines to be the prevailing charge for a healthcare service. Charges as set forth in the Signature Care or Anthem contract with a Network Provider or Sponsor.

Network provider

Physicians and other healthcare providers under contract with the respective medical network to provide services to members at a negotiated rate. An out-of-network provider is not under contract with the respective medical network and does not provide a discount.

Open Enrollment

Open Enrollment is a specific time in which Parkview Health benefit-eligible co-workers may enroll for medical, dental and vision coverage as well as other voluntary benefit plans. For the 2024 plan year, the enrollment period will be in mid-November 2023.

Out-of-Pocket (OOP) limit for network services

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit includes your copayments, deductibles and co-insurance payments.

Parkflex Healthcare and Dependent Care Flexible Spending Account

The Parkflex account provides a way for you to pay for certain unreimbursed healthcare expenses and dependent (for example, your children) and elder care expenses with pre-tax dollars. Contributions you make to your own Parkflex account are made before income taxes are deducted.

Parkview Care Partners

Parkview Care Partners (PCP) is Parkview's clinical integration program which facilitates the coordination of patient care across medical conditions, providers, settings and time. The result is patient-centered care that is safe, timely, effective and efficient, meeting or exceeding national quality standards. Select providers have been named under PCP and those specific providers will be considered Special Access. Applicable to the Signature Care plan only.

Prior authorization

A decision by the Plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization or precertification. Some services may require preauthorization before you receive them, except in an emergency. Preauthorization is not a promise your health insurance or plan will cover the cost. For these specific medical services, you must call your medical plan for prior authorization.

Qualified status change

A qualified status change refers to those times in which you have a change in your FTE status or family status, such as a change in employment, marriage or birth of a child. Any changes to your coverage level must be submitted with 31 days of the qualifying event.

Well-being

Well-being is a balance of physical, spiritual, psychological and social elements of who we are. When you take action for balancing all four areas of your life, you can move forward along the path to greater well-being.

PARKVIEW
HEALTH