2025

Benefits at a Glance Guide

This publication contains important information about your employee benefit program.

Please read thoroughly.

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SIH Commitment to Care

The commitments below are the behaviors expected from all SIH employees, as part of their overall work performance, in order to deliver excellence. These behaviors align with the SIH mission, vision and values that are the foundation of our organization, guiding us to create a culture unified by our Commitment to Care.

01. Commitment to Deliver Positive Patient and Colleague Experiences

We are committed to providing the highest quality of service and utmost care because everyone deserves to be treated with respect and compassion.

- I will be considerate and listen carefully to everyone.
- I will use common courtesy and act with compassion to acknowledge the discomfort (anxiety, fear, stress, uncertainty, pain) of others.
- I will withhold judgment and display sensitivity and respect for others' cultures or traditions, including race, nationality, appearance, beliefs, gender, age, disability, sexual orientation, religion, education or socioeconomic status.

02. Commitment to Support a Collaborative, Inclusive Community

We believe that leadership is within each of us and that each person may work in a different way; therefore, open and honest communication with each other is critical to our success. We value the dignity and unique strengths of each person.

- I will respect everyone regardless of job title, expertise, level of education or certification and/or any other differences that may exist between us.
- I will accept responsibility for establishing and maintaining healthy interpersonal relationships with everyone. I will talk to a co-worker promptly if I am having an issue with them and work toward a respectful resolution.

03. Commitment to Build Trust

It is our responsibility to earn the trust of our patients, guests, co-workers, and community.

- I will speak positively and use discretion when discussing my work in public.
- I will keep my commitments and be honest in all interactions.
- I will practice integrity and maintain confidentiality as outlined by our policy and procedures.

04. Commitment to Embrace my Personal Responsibility

We recognize a sense of ownership toward our job and accept responsibility for our work performance. Our culture recognizes success through collaboration and individual accountability.

- I will speak up as appropriate when I see room for improvement in our processes, behaviors or approach without placing blame or fearing retribution and seek to offer possible solutions to problems.
- I will take the time to keep up with communications from SIH and apply this information to my work.
- I will do my part to ensure a safe environment free of physical and emotional harm.
- I will adhere to organizational and departmental policies.
- I will strive to do every job right the first time.
- I will work with my team to ensure that our priorities and tasks are aligned with the organization's goals and that these jobs are completed in a timely manner.

SIH is a mission-driven organization which strives to create a strong culture of compassionate care, safety and quality that embodies our core values:

Mission

We are dedicated to improving the health and well-being of all of the people in the communities we serve.

Vision

Creating a healthy Southern Illinois made stronger by acts of caring that transform lives

Values

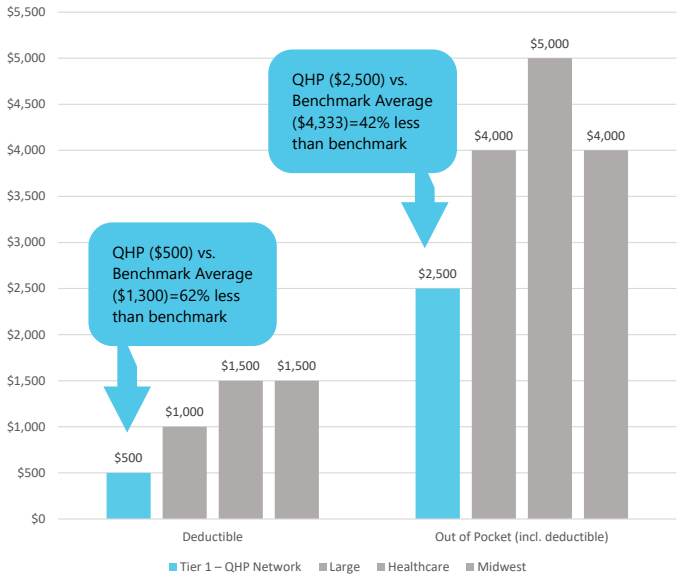
Respect
Integrity
Compassion
Collaboration
Stewardship
Quality
Accountability

SIH

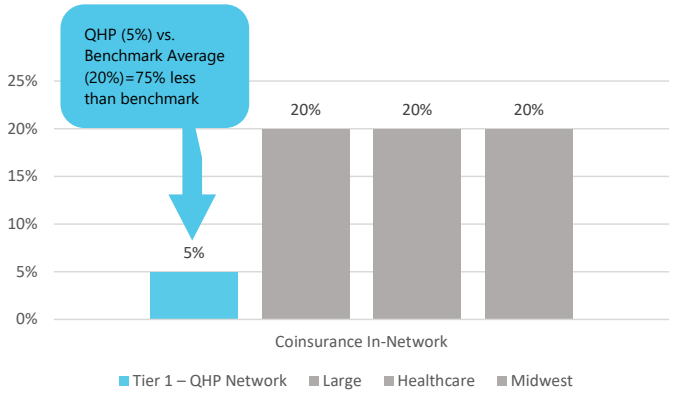
Plan Comparison: SIH QHP Network Versus Benchmark Average

The graphs below demonstrate SIH's competitive benefits in comparison to other employers.

Deductible and Out-of-Pocket Maximums (Single)



Coinsurance Employee Responsibility



SIH Partnership Contacts

SIH Total Rewards Team	
Human Resources 2 Nutrition Plaza	**618.457.5200**
Julie Neubig, HR Director Total Rewards	ext. **67807** **julie.neubig@sih.net**

Total Rewards Team—**https://hub.sih.net/benefitsassistance**	
Benefits	**benefits@sih.net**
Renae Edwards, HR Benefits Coordinator	ext. **67845** **renae.edwards@sih.net**
Sara Bevis, HR Benefits Analyst	ext. **67810** **sara.bevis@sih.net**

Wellness	
www.sihwellness.com (to review personal wellness platform)	**wellness@sih.net** ext. **67827** **618.457.3075**

Leave and Absence (FML, STD, LOA, Return to Work)	
LOA	ext. **67828** **loa@sih.net**
Brooke Vancil, HR Leave and Absence Representative	ext. **67853** **brooke.vancil@sih.net**
Esther Kabwe, HR Leave and Absence Case Navigator	ext. **67826** **esther.kabwe@sih.net**

Compensation	
Salena Alkhatim, HR Compensation Analyst	ext. **67895** **salena.alkhatim@sih.et**

Benefit Enrollment/COBRA

Businessolver, Inc.
PO Box 310552; Des Moines, IA 50331-0552
Benefit Service Center (enroll/make changes) | **844.386.2375**
Dependent Verification Fax (to fax dependent documentation)
515.343.2246
benefits.sih.net (to enroll or make changes)
COBRA | **877.547.6257**

Medical—Allegiance, a Cigna Company

855.999.1052
Refer to **www.askallegiance.com/SIH** to locate providers, confirm provider network status, access your online account, or find an EOB

Prescriptions—MaxorPlus

800.687.0707 | www.maxorplus.com
MaxorPlus Customer Service
MaxorPlus Mail Order: **800.687.8629**
Maxor Specialty Pharmacy: **866.629.6779**

SIH Employee Pharmacy

Herrin Pharmacy: **618.351.8321**

Dental/DPPO—Cigna

800.244.6224 | www.cigna.com

Vision—Eyemed

866.9EYEMED | www.eyemed.com

Flexible Spending Account Program including Healthcare and Dependent Care—Allegiance

855.999.1052 | www.AllegianceFlexAdvantage.com

Life and Accidental Death and Dismemberment (AD&D)—New York Life Group Benefit Solutions

Life Claims: **800.362.4462**

Family Medical Leave (FML)/Short Term Disability (STD)—SIH Leave and Absence Department

618.457.5200 ext **67828 | LOA@sih.net**

Long Term Disability (LTD)— New York Life Group Benefit Solutions

800.362.4462

Voluntary Benefits—Allstate Benefits

Group Critical Illness, Group Hospital Indemnity, Group Accident, and Group Term to Age 100 Life
866.828.8501 | www.allstatebenefits.com/mybenefits

401(k)/Roth Contribution—Empower

Retirement planning and 401(k) offered through Empower
833.SIH.401K | empowermyretirement.com

Appointment Scheduler: Empower (sih.empowermytime.com/#/)

Medicare Basics	Christine Thompson, Medicare Counselor	Ext. **67856** **christine.thompson@sih.net**

Employee Assistance Program—PAS

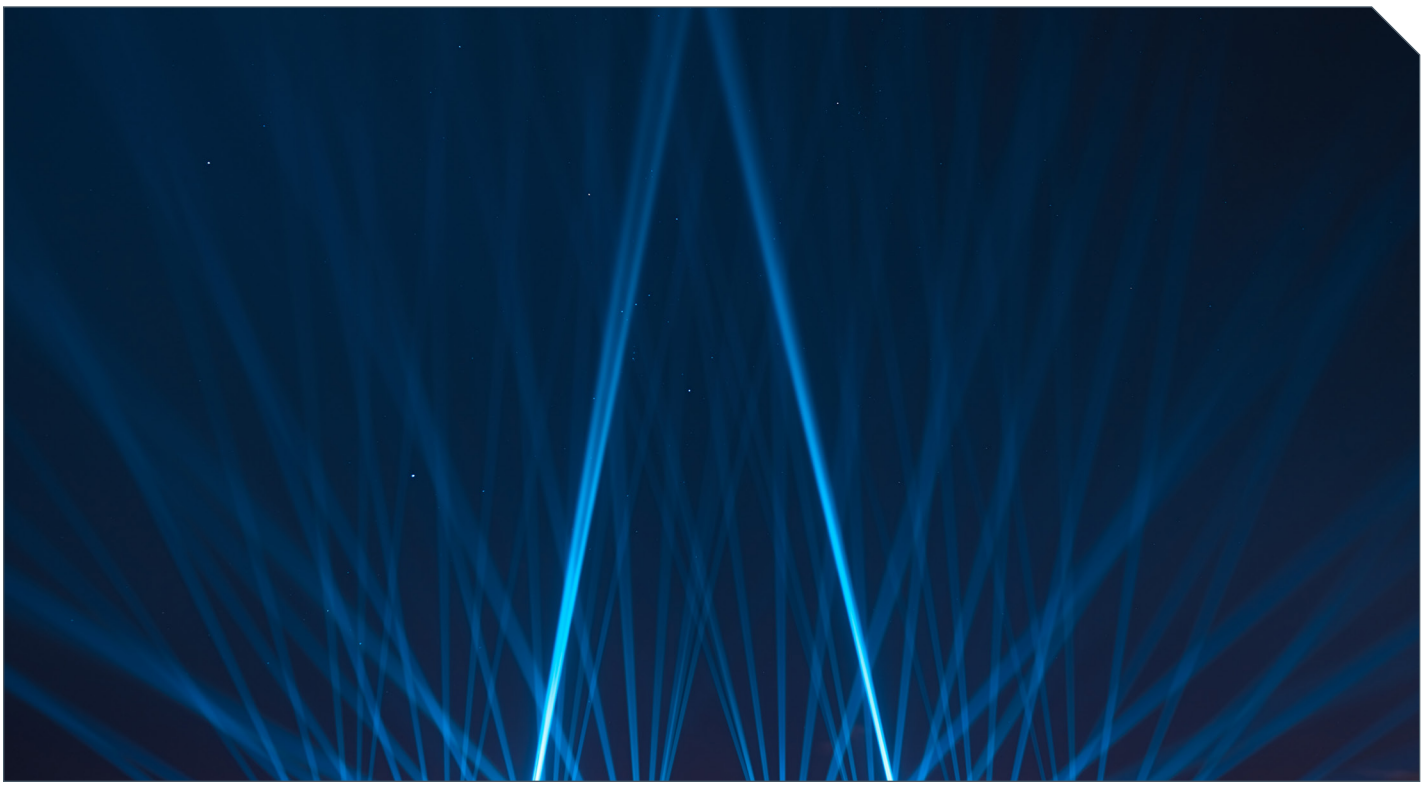
Personal Assistance Services (PAS) **800.356.0845** **www.mypaseap.com**	**Organization Code: SIH** RxWell Mobile App eM Life Mobile App Search RxWell and/or eM Life in the app store on your mobile device

Steps To Enroll In Benefits

1. Go to **benefits.sih.net**
2. Login using your SIH computer username and password from work or home
   A. If accessing the website from a personal computer:
   USERNAME: Your SIH email
   PASSWORD: Your SIH computer login password
   B. If accessing the website from a work computer, you will be automatically signed in thanks to the single sign on (SSO) feature
3. After logging in and landing on the Home page, explore the benefit tabs, videos, and other resources to help you make your decisions
4. After exploring your benefit options and determining which benefits you would like to elect, click "Start Here" and follow the prompts
5. Click "Approve" once you have reviewed and finalized your elections
6. Confirm your choices officially by clicking "I Agree." Ensure you receive a confirmation number anytime you enter the portal
7. You are able to print your election information for your records or your elections will be saved on this site to review at anytime throughout the year
8. If you are choosing to enroll family members, please see the following page with more details about family member enrollment instructions and required documentation

Contact the Benefit Service Center at **844.386.2375** with questions about navigating the Enrollment website, or to assist you with electing benefits.

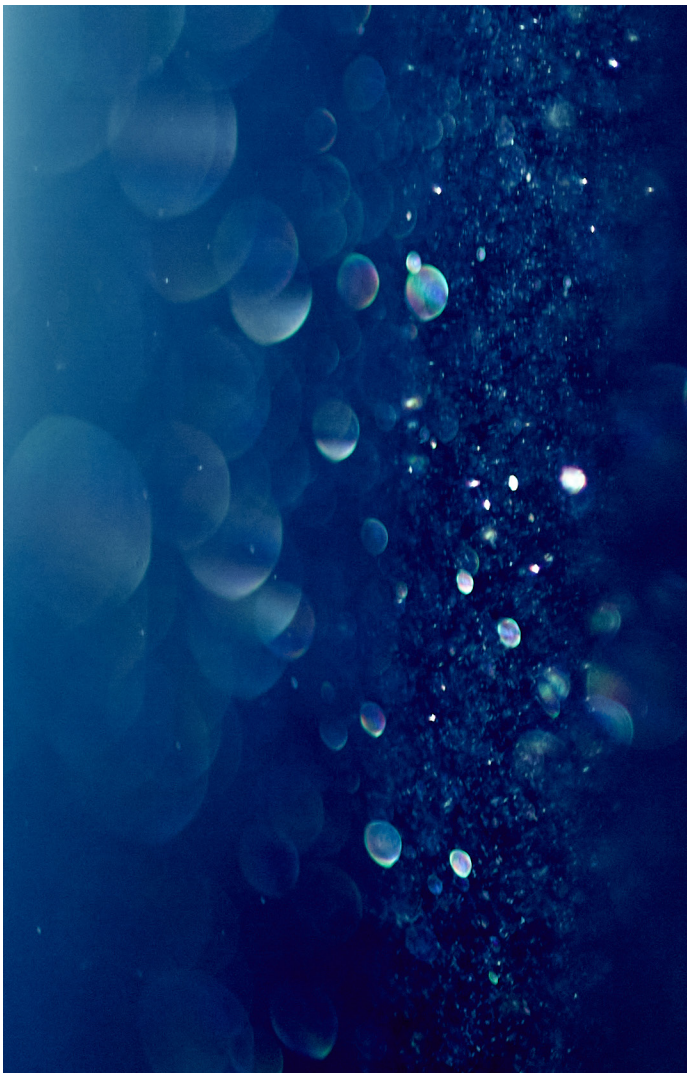
Representatives are available Monday-Friday, 7:00 a.m.–7:00 p.m. CT



Scan to access
benefits.sih.net

One on One Meetings for Benefit Questions

To ensure you understand your benefits, SIH offers the opportunity for a one on one meeting regarding your benefits. The following link provides you to schedule an onsite or virtual one on one meeting: **https://hub.sih.net/benefitsassistance**.



Want to Review Your Plan Information?

You have year-round access to your benefit summary and specific benefit elections at **benefits.sih.net**.

1. Click your name and then benefit summary
2. Review your plans

Year Round Resources Available at benefits.sih.net

Take time to read, watch, and learn from the resources about your 2025 Benefits provided by SIH. Once logged in to **benefits.sih.net**, select from any of the following tabs:

- **Your Health**—includes details about our medical and prescription drug program
- **Your Life**—includes details about our life and disability options available
- **Voluntary Benefits**—includes information about the voluntary benefits available through Allstate
- **SIH Employee Wellness Program**—includes details about our Wellness program
- **Your Finances**—includes details about our 401(k) program
- **Enrolling/Changing Benefits**—includes hints and tips regarding what to do if experiencing a life event during the year
- **Benefit Videos**—includes videos about topics specific to SIH's benefit program
- **Resources**—includes links to rates, Benefit Guides, Summary Plan Documents, and further details about our plans

Enrolling Family Members

Information You Need

The following information is required if you are adding family members.

1. Social Security Numbers, dates of birth, and addresses for family members.
2. Qualified documents to enroll family members:

Documents to Enroll Your Legal Spouse
▶ If you decide to add a spouse to the medical insurance, you must complete the applicable sections of the Affidavit of Spousal Healthcare Coverage. This document can be obtained from HR Benefits Department.
▶ If married less than 12 months and you and your spouse have not filed a joint federal income tax return, a government-issued marriage certificate, and a document dated within the last 60 days showing current relationship status (examples: recurring monthly household bill or statement of account); the document must list your spouse's name, date and current mailing address.
▶ If you and your spouse have been married for 12 or more months, a government-issued marriage certificate, and a Tax Return Transcript of your most recently filed federal joint income tax return.
Documents to Enroll Your Children Under 26 Years
▶ A copy of the child's government-issued birth certificate or adoption certificate naming you or your spouse as the child's parent. Please note: the document must list the first and last name of the child and parent(s); or if under 6 months of age **ONLY**, hospital documentation reflecting the child's birth, naming you as parent.
OR
▶ A copy of the court order naming you or your spouse as the child's legal guardian or custodian.
Documents to Enroll Overage Dependent Child(ren)
▶ A copy of the child's government-issued birth certificate or adoption certificate naming you or your spouse as the child's parent. Please note the document must list the first and last name of the child and parent(s); or if under 6 months of age **ONLY**, hospital documentation reflecting the child's birth, naming you as parent, or a copy of the court order naming you or your spouse as the child's legal guardian or custodian. You do not need to wait for a Social Security card or Birth Certificate to enroll your newborn child. You may enroll them with hospital documentation.
AND
▶ A copy of your most recently filed Federal Tax Transcript listing the child(ren) as your tax dependent.
▶ Your physician will need to confirm disabled status; to obtain the physician form, please contact Allegiance at **855.999.1052** in addition to providing the above documentation.

Note: If you are covering a stepchild or child for whom your spouse has legal guardianship, you must also provide documentation of your current relationship to your spouse as requested above.

3. Upload these documents into the enrollment portal **benefits.sih.net** or fax to **515.343.2246**.
4. Your family member(s) will NOT be added to the plan until the documentation has been received and verified. Check your message center for confirmation.
5. If documentation is not supplied within 31 days from your event, including from your hire date or from when you become newly eligible, your family member(s) will not be covered.

Benefit Eligibility

Regular full-time employees who work 72 hours or more per pay period are eligible for all employee and employer paid benefit plan options. Regular part-time employees who work 40–71 hours per pay period are eligible for all employee paid benefit plan options, but will pay a higher rate for medical/health insurance.

Per diem employees who average 30 hours or more per week of actual time worked after a 12-month look-back period are eligible for medical coverage only. Per diem employees who meet the eligibility criteria for medical benefits after the 12-month look-back will be notified and will have an opportunity to participate in a special enrollment period. Per diem employees are not eligible for any voluntary or supplemental benefits, such as dental, vision, supplemental life, or Allstate products.

Affordable Care Act (ACA) regulations require employers to offer medical coverage at the full-time rate to all employees who work 30 hours or more per week of actual time worked. This hourly requirement will be monitored regularly. Therefore, per diem or part-time employees who are scheduled to work less than 30 hours per week but who average 30 hours or more hours per week of actual time worked over the defined measurement period will be offered medical coverage at the full-time rate.

Your Benefit Options

You and your eligible family members can choose from the following options:

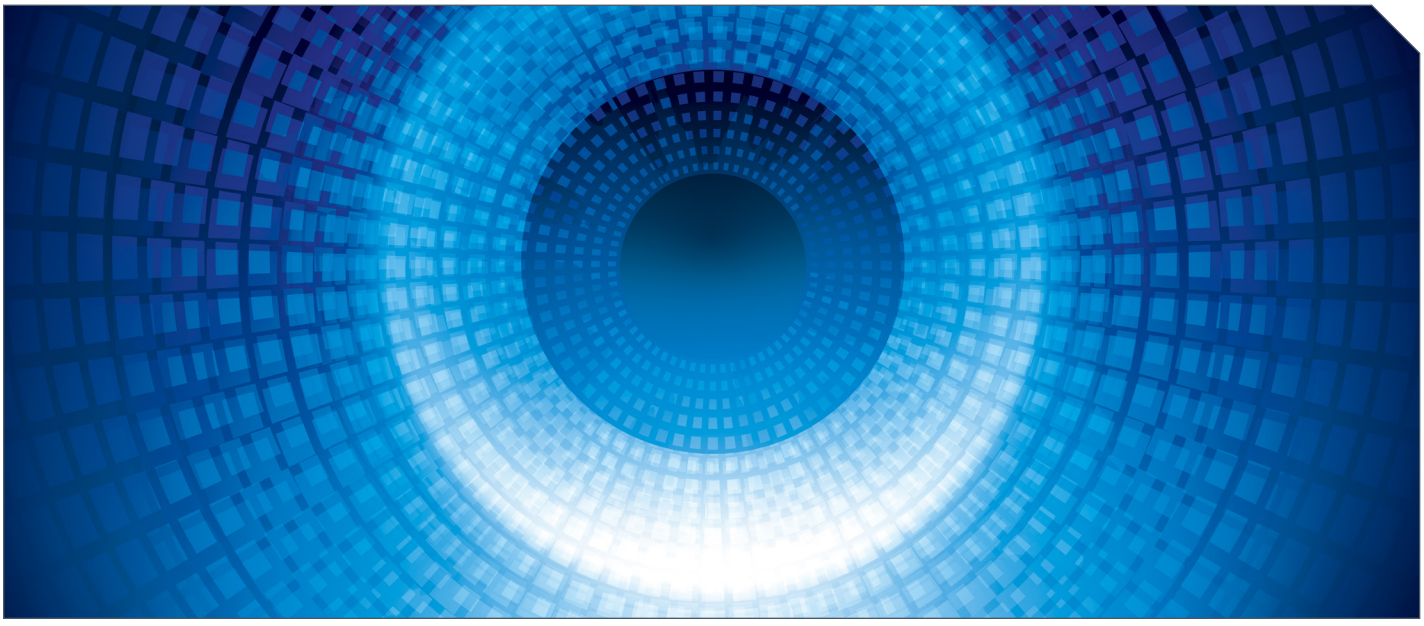
- Medical—Allegiance—which includes prescription drug coverage—company and employee-paid.
- Dental—Cigna—employee-paid.
- Vision—EyeMed—employee-paid.
- Basic Life and accidental death and dismemberment (AD&D)—New York Life—company-paid; this coverage is automatically enrolled.
- Supplemental employee life and accidental death and dismemberment (AD&D) insurance— New York Life—employee-paid.
- Dependent life insurance—New York Life—employee-paid.
- Short term disability insurance (STD) offered after one year of full-time service—company-paid; this coverage is automatically enrolled.
- Long term disability insurance (LTD)—New York Life—offered after one year of full-time service—company-paid; this coverage is automatically enrolled.
- Long term disability buy up—New York Life—an additional 10% of long term disability coverage—employee-paid.
- Flexible spending accounts (FSAs)—Allegiance—healthcare FSA or dependent care FSA—employee-paid.
- Voluntary plans including Group Critical Illness, Group Hospital Indemnity, Group Accident, and Group Term to Age 100 Life Insurance coverage—Allstate—employee-paid.

Definition of an Eligible Family Member

An eligible family member is defined as:

- **Your spouse**—The person to whom you are legally married.
- **Your child**—Your biological child, child with a qualified medical support order, legally adopted child, or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws through the end of the month in which he/she turns age 26.
- **Your stepchild**—The child of your spouse for as long as you remain legally married to the child's parent through the calendar month in which he/she turns age 26.
- **Your foster child**—A child that has been placed in your home by the Illinois Department of Children and Family Services Foster Care Program or the foster care program of a licensed private agency through the end of the calendar month in which he/she turns age 26.
- **Legal guardianship**—A child for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state or federal laws or a child for whom you are granted court-ordered temporary or other custody through the end of the calendar month in which he/she turns age 26.
- **Overage dependent child(ren)**—Your covered child with intellectual or physical disabilities. This child may continue insurance coverage after reaching age 26 and while remaining continuously covered, or the child was over the age of 26 at the time of your initial enrollment. The child must be incapable of self-sustaining employment because of the intellectual or physical disability, and be dependent on you for care and financial support.

Note: if you and your spouse are both eligible employees, only one of you may cover a dependent child. In addition, you may not be enrolled as both an employee and as a dependent spouse at the same time.



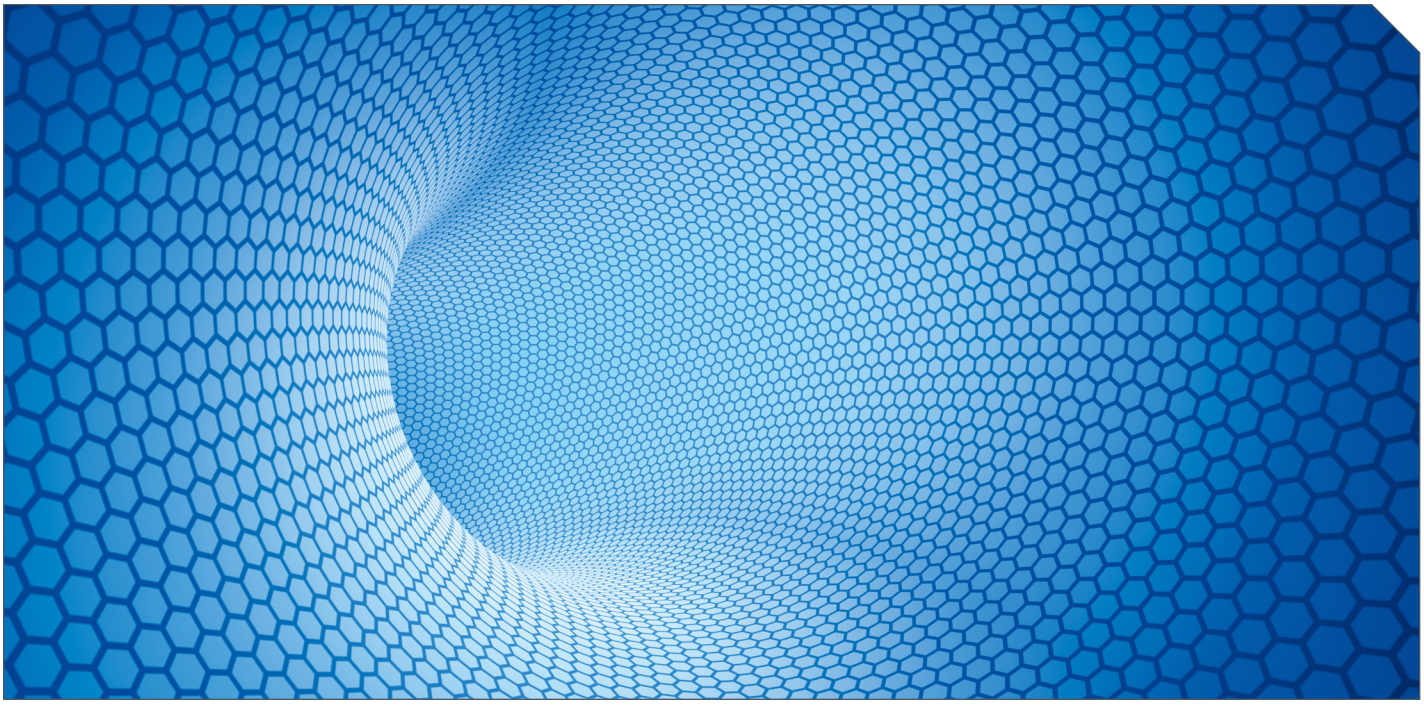
Working Spouse Contribution

Spouses who are eligible for their own employer's group medical coverage but choose to be covered by SIH's plan will pay a $75 per pay period working spouse contribution.

The additional contribution will not apply if:

- You do not have a spouse
- You do not enroll your spouse in the SIH medical plan
- Your spouse is not employed or is employed part-time, temporarily, or on a short-term contractual basis
- Your spouse is self-employed and is not eligible for group medical coverage
- Your spouse is employed, but is not eligible for group medical coverage from his/her employer
- Your spouse is not employed and has access to medical coverage in a government-sponsored medical plan such as Medicare, Medicaid, or Tricare
- Your spouse is not employed and has access to medical coverage through a retiree medical plan from his/her former employer
- Your spouse is employed by an SIH entity

As part of the benefits enrollment process, you will be asked to complete an Affidavit of Spousal Healthcare Coverage. In this affidavit, you will complete the applicable sections that answer whether your spouse has access to a group medical plan from his or her own employer. You will also be asked the name, address, and phone number of your spouse's employer. If you are not including your spouse on medical coverage, you can answer "Not Applicable" for each of the questions on the questionnaire. Failure to answer truthfully is considered fraud and can result in termination of employment.



Frequently Asked Questions About the Working Spouse Contribution

Q If my spouse elects coverage at his/her employer and wants secondary coverage through SIH, will we still have to pay the additional $75 per pay?

A Yes.

Q My spouse works part-time and is eligible for group medical coverage, but at a very high cost. Would I still have to pay the $75 working spouse contribution?

A No, because your spouse is employed part-time, not full-time.

Q If I remove my spouse from the SIH medical option, can I still enroll him/her in dental and vision benefits?

A Yes, the working spouse contribution applies only to the medical option.

Q What happens if my spouse is not employed when I make my benefit elections and then later in the year he/she gets a job and is offered medical coverage?

A Because you indicated during benefits enrollment your spouse was not eligible for medical through his/her employer, the added contribution will not apply to you for the remainder of the calendar year in which you enrolled. However, if your spouse takes their employer's benefits, you have 31 days to remove them from your plans.

Q If I'm paying the working spouse contribution and experience a life event (e.g., divorce) which allows me to remove my spouse from the SIH medical plan, will my spousal contribution end when my spouse's SIH medical coverage ends?

A Yes, the contribution will cease if your spouse is removed from the medical plan due to a life event or loses eligibility for group coverage.

Q Will there be an additional cost to have my children on the SIH medical plan if we have access for them to be covered on my spouse's medical plan?

A No.

Q When does the paycheck contribution begin?

A Initially on the first paycheck in January 2025 if enrolling spouse for the first time during open enrollment. Throughout the year, it will appear on new employees' paychecks at the same time as their first medical plan deduction. If medical coverage begins due to a life event, the contribution will appear at the same time as the first medical plan deduction.

Q How will the contribution be denoted on my paycheck?

A The working spouse contribution is located in the pretax deductions section on your paycheck stub.

Life Events—Qualified Status Changes During the Year

You can change your coverage during the year only if you experience a qualified change in status consistent with IRS regulations for a cafeteria 125 plan. Changes must be made within 31 days of the qualified change in status event date. Information on this type of plan can be found at **www.irs.gov**. Examples of a qualified change in status:

- If you add or lose a family member(s) through marriage, divorce, birth, adoption, or death
- Termination of spouse's employment or commencement of employment by spouse
- Loss of coverage under another group health plan
- Your employment status changes from full-time to part-time or per diem
- Your employment status changes from part-time or per diem to full-time

Waiving Coverage

If you waive healthcare coverage for yourself and your eligible family members because you have other coverage, you can elect coverage with SIH at a later date if you involuntarily lose your other coverage or acquire a new family member.

Making Changes

To make changes, please go online to **benefits.sih.net** or call the Benefit Service Center at **844.386.2375.**

You must make the election change within 31 days of the qualified life event (60 days in the case of a special enrollment right under the Children's Health Insurance Program Reauthorization Act of 2009).

The change must be consistent with the qualified change in status.

Your coverage will be effective or terminate on the date of the event.

If you do not change your elections within 31 days of a qualified change in status event which causes your family members to lose eligibility under the option, the ineligible family member's coverage will still terminate as of the last day of the month, or as of the event date, in which he or she became ineligible. You will be responsible for any claims paid after your family member became ineligible.

For a more detailed guide regarding qualified life events, you can access the Qualified Status Change Guide year-round. Visit the benefits enrollment site at **benefits.sih.net**.

When Coverage Begins

In general, coverage for you and your eligible family members will begin on the first day of the month after your hire date or you become newly eligible, provided you complete the online enrollment by the end of the month you are hired or become newly eligible. If you are enrolling during annual enrollment, coverage begins on January 1st each year.

When Coverage Ends

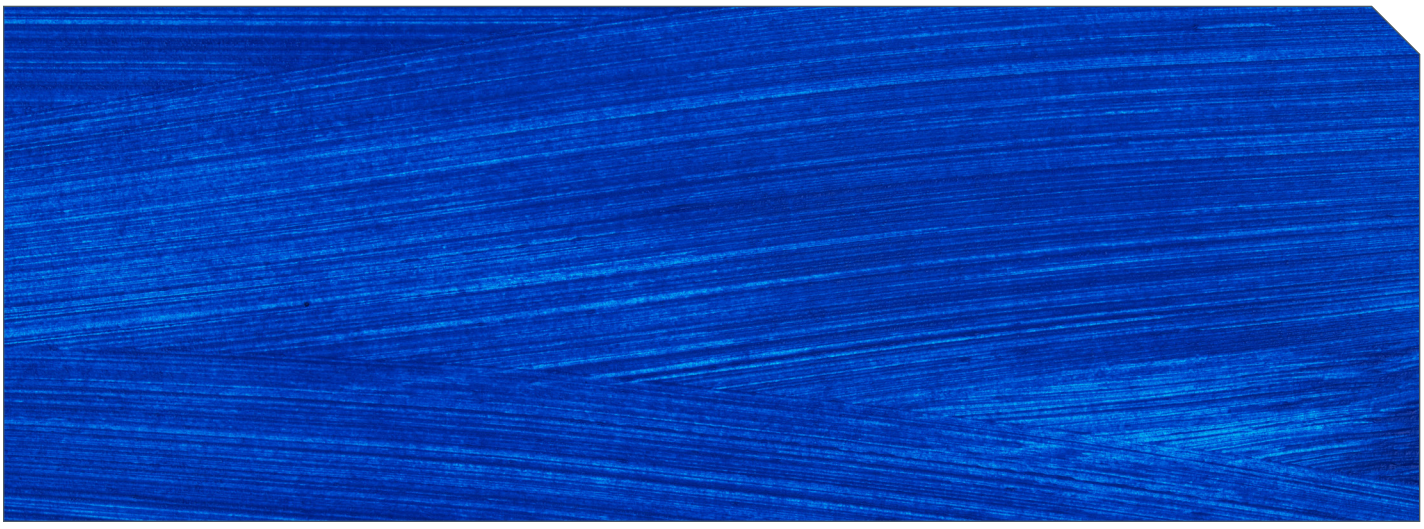
In general, coverage for you and your covered family members will end either on the 15th or the last day of the month, depending on the date you terminate employment. If you cancel coverage during annual enrollment your coverage will end on the last day of the calendar year. For employment status changes, such as changing from full-time employment to per diem, coverage will terminate the date of the employment change.

Please note: due to ACA regulations, medical coverage will not automatically terminate for employees who are in their stability period (i.e., employees changing from full-time to per diem). Employees who are in their stability period will need to actively take steps to terminate medical coverage by going to benefits.sih.net or by calling the Benefit Service Center at 844.386.2375.

COBRA Continuation of Coverage

You and your qualified family members may be offered COBRA continuation coverage when your coverage under the plan (e.g., medical, dental and/or vision) would otherwise end because of a "qualifying event." Failure to enroll in benefits during the open enrollment period is not a COBRA event.

Businessolver, SIH's Benefit Enrollment/COBRA Administrator, will mail you the COBRA paperwork and you will make your decision directly through them. Should you have any questions regarding your COBRA coverage, Businessolver can be reached by calling **877.547.6257**.



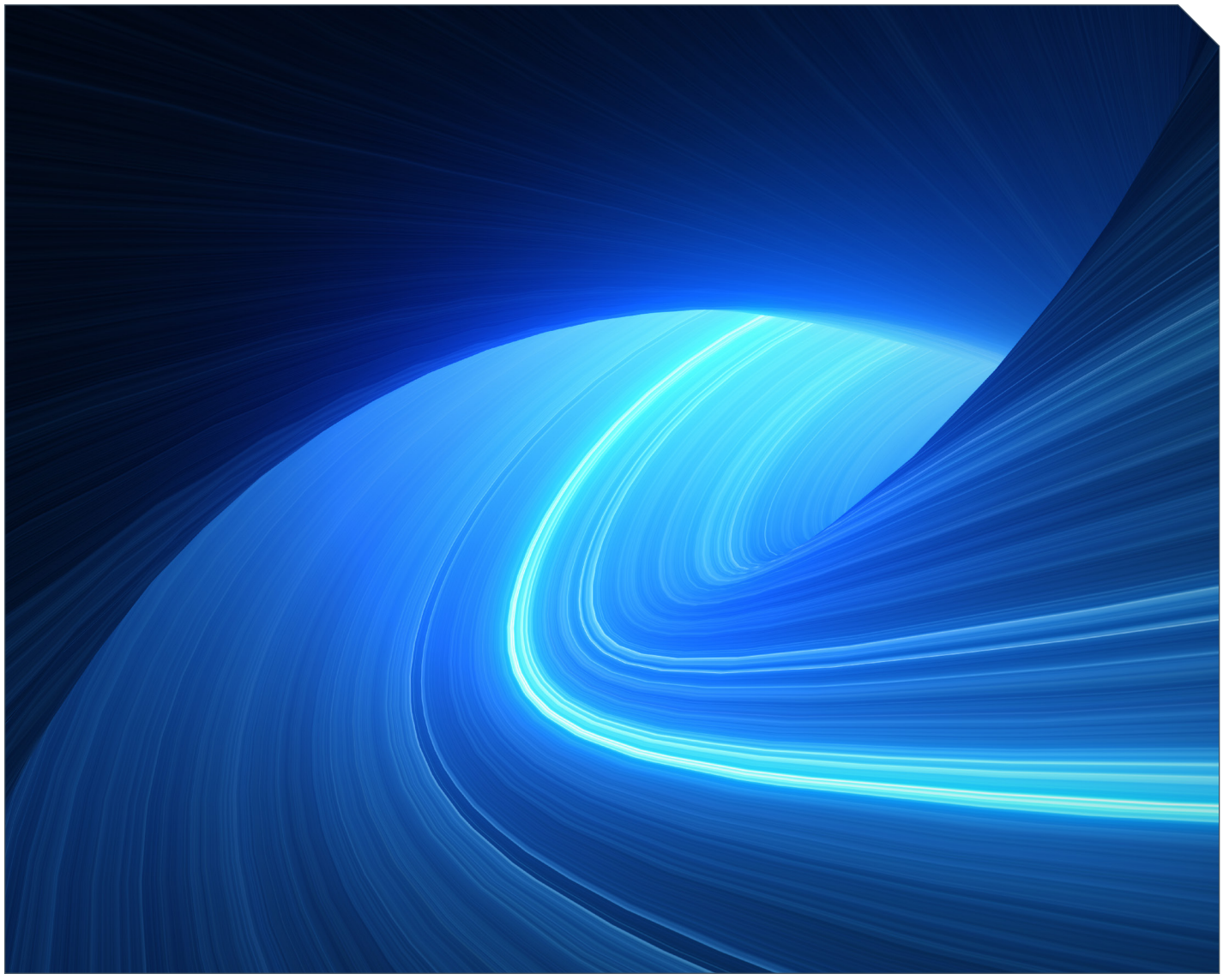
Changes Allowed Due to Change in Family Status Event

Medical, Dental, and FSA	Life, AD&D, and Disability Insurance	Dependent Care Spending Account
Marriage, Birth, or Adoption		
▶ See HIPAA special enrollment rights for medical coverage ▶ You may add your new spouse or newly acquired dependent child to your current medical and dental coverage ▶ You may increase your FSA deposit ▶ You may drop SIH coverage if you enroll for coverage under your new spouse's plan	You may either increase or decrease your coverage	You may increase or decrease your election if the event affects your dependent care expenses
▶ You must drop coverage for the affected family member ▶ You may decrease your FSA deposit	You may either increase or decrease your coverage	You may increase or decrease your election if the event affects your dependent care expenses
Change in the Employment Status of SIH Employee (e.g., change between full-time to part-time)		
▶ You may add SIH coverage if your premium contributions decrease ▶ You may drop SIH coverage if your premium contributions increase ▶ You may change your FSA deposit if the event affects eligibility for health coverage	You may either increase or decrease your coverage	You may increase or decrease your election if the event affects your dependent care expenses
Dependent Loses Benefit Eligibility (reaches limiting age)		
▶ You must drop the affected family member's coverage ▶ You may increase your FSA deposit if the family member remains eligible under FSA ▶ You may decrease your FSA election if the family member no longer qualifies under FSA	N/A	You may decrease your deposit if your dependent ceases to be eligible under Dependent Care Spending Account (DSA)
Loss of Other Medical Coverage by Employee, Spouse, or Child(ren)		
▶ See HIPAA special enrollment rights for medical coverage	N/A	N/A
Employee or Dependent Becomes Eligible or Loses Eligibility to Medicare or Medicaid		
▶ See HIPAA special enrollment rights for medical coverage ▶ You may drop coverage upon enrollment for Medicare or Medicaid ▶ You may enroll for coverage upon loss of Medicare or Medicaid eligibility	N/A	N/A
Court Issued Order Regarding Medical Coverage of a Child (qualified medical child support order)		
▶ You may enroll yourself and/or the child in the plan and increase your FSA deposit if you are required to provide coverage ▶ You may drop coverage or reduce your FSA deposit if another individual is ordered to provide coverage	N/A	N/A
Enrollment Period for Coverage Under Another Occurs While Your Benefit Choices are in Effect		
▶ You may drop your coverage if you or a family member becomes covered under the other employer's plan ▶ You may not change your FSA deposit	You may make benefit changes which correspond with coverage choices made under the other employer's plan	You may decrease your deposit if your spouse chooses coverage under an FSA offered by his/her employer

Employment Status Changes and Impact to Benefits

Full-Time to Part-Time Less Than 0.50 FTE	All benefits drop as of your employment status change (except medical for employees still in stability period)
Full-Time to Part-Time 0.80–0.50 FTE	31 days from employment status change to make changes to benefits
Part-Time to Full-Time	31 days from employment status change to enroll in benefits
Full-Time to Per Diem	All benefits drop as of your employment status change (except medical for employees still in stability period)
Part-Time to Per Diem	All benefits drop as of your employment status change (if enrolled in medical, coverage may continue if still in stability period)

Call a Benefit Specialist to confirm impact to your benefits if making changes to your employment status as each individual situation is different.



Health and Welfare Benefits

Network Provider Descriptions

Quality Health Partners (QHP)—is a clinically-integrated, value-driven organization. It is a relationship between physicians, hospitals, and staff members committed to providing high-quality, cost-effective health services to the patients served. It is the formal name of the Physician Hospital Organization (PHO) for SIH. You pay the least out-of-pocket when you receive care or services from a SIH facility or QHP provider. To find the most current listing of providers in the QHP, please visit **askallegiance.com/SIH** and click the Find a Provider tab. See the list of SIH facilities on the next page.

Collaborative Partner network providers—since SIH is a partner with the BJC Collaborative, SIH employees are offered specific discounts only available to partners in the Collaborative. While remaining independent, BJC Collaborative members work together to improve access to and quality of medical care for patients, and create additional efficiencies which benefit our communities, achieve savings, and lower healthcare costs. See the list of these facilities on the next page. These facilities provide you with services at the next lowest cost to you. Deductibles, coinsurance, and copayments are lower than they are for Cigna network or out-of-network providers. Visit **askallegiance.com/SIH** to see a list of providers in the Collaborative Partner network.

Cigna network providers—Cigna's network providers have agreed to our plan's negotiated in-network rates. Your deductible, coinsurance, and copayments will be lower than an out-of-network provider. Visit **askallegiance.com/SIH** to see a list of providers in the Cigna network.

You can choose a provider from any of the networks described above. The Cigna network is our plan's actual network. The QHP network and Collaborative Partner network providers are additional opportunities to receive deeper discounts and savings on your services.

Out-of-network providers—if you receive care from a provider who is not a part of the networks described here, your services may not be discounted. Seeing providers out-of-network will cost you the most out-of-pocket. Charges above reasonable and customary are your responsibility and will not apply to your deductible or annual out-of-pocket maximum. Also, charges applied to your out-of-network deductible and out-of-pocket maximum do not cross accumulate with the in-network expenses.

Network Access and Cross Accumulation

Please pay special attention to the three in-network providers. These are connected when it comes to your deductibles and out-of-pocket maximums. Any expenses you pay for care received in these three networks will cross accumulate.

This means if you pay a $75 bill in the Collaborative Partner Network, $75 will not only apply toward the $1,500 deductible for the Collaborative Partner Network, but it will also accumulate toward the $2,500 deductible which applies to the Cigna network as well as the $500 deductible which applies to the QHP network. This will allow you to receive greater cost savings with the plan while utilizing all three provider networks.

Listing of Facilities—SIH and Collaborative Partners

SIH Facilities

- Center for Medical Arts
- Memorial Hospital of Carbondale
- Harrisburg Primary Care Group
- Harrisburg Medical Center
- The Breast Center
- SIH Cancer Institute
- Miners Memorial Health Center
- Herrin Hospital
- Physician Surgery Center at CMA
- Logan Primary Care
- St. Joseph Memorial Hospital
- Rehab Unlimited
- Sleep Disorders Center
- Orthopaedic Institute of Southern Illinois Surgery Center
  (includes physician services and all imaging; all other services, such as labs, rehabilitation, and physical therapy are covered at the Cigna level of network discount; locations in Illinois only)

SIH Facilities for Labs and Imaging*

- Center for Medical Arts
- Memorial Hospital of Carbondale
- Harrisburg Primary Care Group
- Harrisburg Medical Center
- The Breast Center
- SIH Cancer Institute
- Miners Memorial Health Center
- Herrin Hospital
- Logan Primary Care
- St. Joseph Memorial Hospital

Collaborative Partner and BJC

- Abraham Lincoln Memorial Hospital
- Alton Memorial Hospital
- Anderson County Hospital
- Barnes-Jewish Hospital
- Barnes-Jewish Siteman Cancer Center
- Barnes-Jewish St. Peters Hospital
- Barnes-Jewish West County Hospital
- Blessing Hospital
- Christian Hospital
- Cox Medical Center Branson
- Cox Medical Center South
- Cox Monett Hospital
- Cox North Hospital
- Crittenton Children's Center
- Decatur Memorial Hospital
- Hendrick Medical Center
- Illini Community Hospital
- Memorial Hospital Belleville
- Memorial Hospital East
- Memorial Medical Center
- Meyer Orthopedic & Rehabilitation Hospital
- Missouri Baptist Medical Center
- Missouri Baptist Sullivan Hospital
- Parkland Health Center—Bonne Terre
- Parkland Health Center—Farmington
- Passavant Area Hospital
- Progress West HealthCare Center
- Rehabilitation Institute of St. Louis
- Saint Luke's Cushing Hospital
- Saint Luke's East Hospital
- Saint Luke's Hospital of Kansas City
- Saint Luke's North Hospital—Barry Road
- Saint Luke's North Hospital—Smithville
- Saint Luke's South Hospital
- Sarah Bush Lincoln Health Center
- St. Louis Children's Hospital
- Taylorville Memorial Hospital
- Wright Memorial Hospital

* The medical deductible will not apply when diagnostic services are billed under these facilities' tax ID numbers. Any services billed outside of diagnostic (i.e. surgical) or if billed under the provider's tax ID rather than the facility, the deductible will apply.

Some hospitals and other locations are excluded from our medical plan. Services at these places will not be covered by our medical plan unless it is a true emergency. A true emergency is a traumatic injury or medical condition which occurs unexpectedly and which, if not immediately treated, might cause complications or jeopardize the patient's full recovery. True emergencies include heart attacks, cerebral vascular accidents (strokes), poisonings, loss of consciousness, severe shortness of breath, profuse bleeding, broken bones, and convulsions. Observation room services as a result of emergency room care and similar conditions may also be determined by a physician to be medical emergencies.

Excluded Facilities and Locations from Medical Plan*

Excluded Facilities
▶ Cedar Court Imaging in Carbondale, IL
▶ Crossroads in Mt. Vernon, IL
▶ Deaconess Hospital in Evansville, IN
▶ Heartland Regional Medical Center in Marion, IL
▶ Lourdes Hospital in Paducah, KY
▶ Physicians Surgery Center at Good Samaritan, Mt. Vernon, IL
▶ Saint Francis Medical Center in Cape Girardeau, MO
▶ Southeast Hospital in Cape Girardeau, MO
▶ Southern Illinois GI Specialists in Carbondale, IL is excluded including physician charges under Dr. Zahoor Makhdoom
▶ SSM Good Samaritan in Mt. Vernon, IL
▶ SSM St. Mary's in Centralia, IL
▶ Union County Hospital in Anna, IL (including the Convenient Care Clinic)
▶ Western Baptist in Paducah, KY

* Exclusions include these locations and any location billing under the same Tax ID.

Visit **askallegiance.com/SIH** and click the Find a Provider tab for a listing of in-network and excluded providers.

Medical

SIH offers full-time employees who work 72+ hours per pay period, part-time employees who work 40-71 hours per period, and ACA eligible employees the Cigna Open Access Plus Plan.

If adding family members to your medical enrollment, don't forget to complete the Coordination of Benefits Form (COB). Employees will be asked to complete the Coordination of Benefits Form around February, 2025. There are three options to complete the Coordination of Benefits Form:

1. Return questionnaire by mail
2. Online by visiting **askallegiance.com/SIH**
3. By phone by calling **855.999.1052**

Claims will not be paid until your COB is completed and returned.

Please note: if your spouse is also an employee of SIH, you will need to choose employee coverage under your own plan or spouse or family coverage under your spouse's plan. You cannot be enrolled in both.

ID Cards

You will only be issued a new medical ID card if enrolling for the first time, or if you added or removed family members.

Our Medical Plan Includes the Following Features

- **Annual deductible:** what you pay directly to a provider or facility before the plan starts paying a portion of your costs; the deductible only applies to services for which you pay a coinsurance
- **Annual out-of-pocket maximums:** the most any individual or family must pay in any one calendar year for covered services
- **Coinsurance:** the percentage you pay directly to a provider or facility for covered services after you meet the annual deductible
- **Contribution:** what you pay per paycheck for coverage
- **Copayment:** the specific dollar amount you pay directly to a provider or facility for covered services; you pay a copayment when there is no deductible or coinsurance that applies

Medical Plan Design

For SIH full-time employees who work 72 hours or more per pay period, part-time employees who work 40-71 hours per pay period, and ineligible part-time employees or PRN employees who average 30 hours per week of actual time worked after a 12-month look-back.

	QHP* Network Providers	Collaborative Partner Network Providers	Cigna Network Providers	Out-of-Network Providers
Deductible (single/family)	$500/$1,500	$1,500/$4,500	$2,500/$7,500	$4,000/$12,000
Out-of-Pocket Maximum (Single/Family)				
Medical Out-of-Pocket Maximum (single/family)	$2,500/$5,000	$3,500/$7,000	$4,500/$9,000	Unlimited
Pharmacy Out-of-Pocket maximum (single/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Copays/Coinsurance				
Hospital Inpatient	5% after ded.	20% after ded.	30% after ded.	50% after ded.
Outpatient Hospital Surgery	5% after ded.	20% after ded.	30% after ded.	50% after ded.
Other Hospital Outpatient	5% after ded.	20% after ded.	30% after ded.	50% after ded.
Hospice	0% no charge	0% no charge	0% no charge	50% after ded.
Home Healthcare	5% after ded.	10% after ded.	30% after ded.	50% after ded.
Rehabilitative Therapy (up to 60 combined visits per year)	$20 copay	$30 copay	30% after ded.	50% after ded.
PCP Office Visit	$20 copay	$30 copay	$40 copay	50% after ded.
Specialist Office Visit	$30 copay	$40 copay	$50 copay	50% after ded.
Other Physician Services (lab, diagnostic)	5% after ded.	20% after ded.	30% after ded.	50% after ded.
Outpatient Labs, Imaging, and Diagnostic Tests at SIH Facilities	5% (ded. waived)	20% after ded.	30% after ded.	50% after ded.
Preventive Care	0% no charge	0% no charge	0% no charge	50% after ded.
Durable Medical Equipment (DME)**	5% after ded.**	Not applicable	30% after ded.	50% after ded.
Walk-In Clinics/Prompt Care***	$20 copay	$30 copay	$40 copay	50% after ded.
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Emergency Room (true emergency)	$250 copay	$250 copay	$250 copay	$250 copay
Other ER Care (not true emergency)	20% after ded.	30% after ded.	30% after ded.	50% after ded.
Spinal Manipulation ($500 maximum)	50% after ded.	50% after ded.	50% after ded.	50% after ded.
Outpatient Mental Health Services	$20	$20	$20	50% coinsurance ded. waived, not subject to MEE

The medical plan documents are available online at **benefits.sih.net**. If you do not have access to a computer, printed copies are available upon request from Human Resources.

* To find QHP providers, go to **askallegiance.com/SIH**.

** DME goods fulfilled by EviCore and our Client Specific Network follow the QHP rate; EviCore can be reached at **855.999.1052**.

*** What you will pay for SIH prompt care.

Medical Pricing

Market Competitive Pricing

We care about your health, which is why SIH will continue to pay 91% of an employee's single premium and 85% of the family premium. This is in comparison to Midwest employers who pay 75% of the employee's single premium and 68% of family coverage. In healthcare specifically, we see employers paying 76% of the employee's single coverage and 63% of the family coverage. SIH offers a strong, market competitive benefit package along with a design structure and employer funding much richer than the majority of our peers.

For SIH full-time employees who work 72 hours or more per pay period, SIH part-time employees who work 40-71 hours per pay period, and ineligible part-time or PRN employees who average 30 hours per week of actual time worked after a 12-month look-back. Any change in salary may impact medical premiums within the pay period in which the change occurred.

	Total Monthly Rate	SIH Monthly Contribution	Employee Monthly Contribution*	Employee Cost Per Pay Period*
<$40,000 Annual Salary				
Employee Only	$1,248.10	$1,166.10	$82.00	$41.00
Employee + Spouse	$2,621.03	$2,197.03	$424.00	$212.00
Employee + Child(ren)	$2,246.59	$1,968.59	$278.00	$139.00
Employee + Family	$3,993.93	$3,437.93	$556.00	$278.00
$40,000–$69,999 Annual Salary				
Employee Only	$1,248.10	$1,152.10	$96.00	$48.00
Employee + Spouse	$2,621.03	$2,143.03	$478.00	$239.00
Employee + Child(ren)	$2,246.59	$1,906.59	$340.00	$170.00
Employee + Family	$3,993.93	$3,403.93	$590.00	$295.00
$70,000–$99,999 Annual Salary				
Employee Only	$1,248.10	$1,124.10	$124.00	$62.00
Employee + Spouse	$2,621.03	$2,068.03	$553.00	$276.50
Employee + Child(ren)	$2,246.59	$1,846.59	$400.00	$200.00
Employee + Family	$3,993.93	$3,362.93	$631.00	$315.50
$100,000 + Annual Salary				
Employee Only	$1,248.10	$1,109.10	$139.00	$69.50
Employee + Spouse	$2,621.03	$1,996.03	$625.00	$312.50
Employee + Child(ren)	$2,246.59	$1,788.59	$458.00	$229.00
Employee + Family	$3,993.93	$3,313.93	$680.00	$340.00

For part-time employees working 40–71 hours per pay period.

	Total Monthly Rate	SIH Monthly Contribution	Employee Monthly Contribution	Employee Cost Per Pay Period
Employee Only	$1,248.10	$458.10	$790.00	$395.00
Employee + Spouse	$2,621.03	$876.03	$1,745.00	$872.50
Employee + Child(ren)	$2,246.59	$842.59	$1,404.00	$702.00
Employee + Family	$3,993.93	$1,654.93	$2,339.00	$1,169.50

* Employee costs reflect the wellness discount. If wellness requirements are not achieved, rates will increase $250 per month, $125 per pay period.

Prescription Drugs

SIH offers an evidence-based prescription drug program in our prescription drug benefit. MaxorPlus, with recommendations and support by RxResults, LLC, administers this program.

The evidence-based prescription drug program is designed to help keep healthcare costs down for both you and our healthcare plan while promoting healthy outcomes and conforming to national guidelines and/or best practices with respect to drugs used to treat certain medical conditions. Managing prescription costs also helps control future health plan premium costs for our employees.

SIH values and promotes the health of our employees and their covered family members. We believe the evidence-based prescription drug program helps ensure you continue to have a high quality, cost-effective prescription drug benefit.

About MaxorPlus

MaxorPlus is a Pharmacy Benefits Manager helping optimize pharmacy benefit programs and shifting the focus back to you and your care.

With pharmacy benefit services nationwide and access to over 66,000 pharmacies across the US, MaxorPlus provides a clinically focused, evidence-based prescription drug formulary and clinical pharmacy services.

Three-Tier Prescription Benefit

Tier 1: Generic Drugs

You and SIH receive the best value by using FDA-approved generic drugs whenever medically appropriate. For this reason, members pay the lowest copayment ($10*) for generic drugs.

Tier 2: Preferred Brand-Name Drugs

This tier includes many brand-name drugs, which MaxorPlus has determined provide the best value and therapeutic quality for members. Medications in this tier require a higher copayment ($35*) than tier 1 drugs.

Tier 3: Non-Preferred Brand

This tier includes brands that are not on the MaxorPlus Preferred Drug List. Medications in this tier have the highest copay ($60*).

* Some drugs may be Reference Priced and have a different or higher member cost than the standard drug copays. You will be notified if your drug will have a higher cost.

Medication Type	Retail (30-day supply)	Retail/Mail Order (90-day supply)
Tier 1—Generic	$10	$25
Tier 2—Preferred Brand	$35	$87
Tier 3—Non-Preferred Brand	$60	$150

Mandatory Generic

If a Generic equivalent is available and either a Preferred Brand or Non-Preferred Brand drug is dispensed, the Dispense as Written (DAW) penalty will be applied in addition to your copayment. However, if your physician believes a brand-name drug is medically necessary for you, he or she may submit a letter of medical necessity to MaxorPlus for review. If approved, you will still be required to pay the applicable brand copay, but you will not be required to pay the DAW penalty.

Reference Priced Drugs

Reference based pricing applies to drugs (target drugs) that have lower cost, equally effective alternate drugs in certain drug categories. **These target drugs may be brand or generic.** You may decrease your out-of-pocket expense by switching to the lower cost preferred alternative. If you choose to fill the reference priced drug, your out-of-pocket cost will be higher. The plan will only pay the amount it would pay for the preferred alternative(s). You will pay the difference in cost between the target drug and the preferred alternative(s). NOTE: The amount paid by you for the target drug will not apply towards your maximum out-of-pocket.

Filling Your Prescription

You can purchase up to a 30-day supply of medication from any of the types of pharmacies listed in this section. You can obtain a 90-day supply of certain maintenance medications from any of the types of pharmacies listed.

Types of Pharmacies

- **Participating retail pharmacy:** pharmacies who accept your medical ID card and participate in the MaxorPlus pharmacy network. Prescriptions can be either a 30-day or a 90-day supply. You can obtain a list of participating retail pharmacies by signing into your member portal at **www.maxorplus.com** or by calling **800.687.0707**.
- **Mail order pharmacy**: you can choose to utilize the mail order pharmacy, MaxorPlus Pharmacy Mail Service, for your 90-day supply prescriptions needs. Employees can call MaxorPlus Mail order at **800.687.8629**.

Disposing Medications

MedSafe bins are located at our three hospitals and the SIH Cancer Institute. The self-disposal boxes are for controlled (Schedules II-V), noncontrolled, and over-the-counter medicine, including narcotics. Here's what you need to know:

- NEVER dispose of medications for patients or members of your family.
- Do NOT put unused medications from the floor in any MedSafe bin.
- You CAN use the bins to dispose your own medications before or after your shift or on your day off.

MedSafe bins will be locked and unlocked by pharmacy personnel and are regulated by the US Drug Enforcement Agency (DEA).

Hours of Operation

Memorial Hospital of Carbondale and Herrin Hospital:
7:30 a.m.-6:00 p.m., seven days a week

St. Joseph Memorial Hospital in Murphysboro:
7:30 a.m.-6:00 p.m., Monday-Friday 7:30 a.m.-3:30 p.m., Saturday and Sunday

SIH Cancer Institute in Carterville:
7:30 a.m.-3:30 p.m., Monday-Friday

Maintenance Medications

Save money when you purchase a 90-day supply of eligible maintenance medications at a retail pharmacy, E-Pharmacy (see following page for information), or through MaxorPlus Pharmacy Mail Service. After filling two 30-day supplies of maintenance medications at retail, you will be required to fill a 90-day supply at a retail pharmacy or E-Pharmacy.

Advantages to the E-Pharmacy

- Prescriptions filled at work
- Your copay is less than a regular pharmacy
- You may order refills 24 hours a day via automated phone system, online, or smart phone link/app
- You are notified via email or automated call when your prescription is ready
- Pharmacist is available during open hours

Specialty Medications Mail Order Program

Maxor Specialty Pharmacy is the preferred provider of specialty medications. Cost is 20% (no deductible) to maximum out-of-pocket per script of $125. Maxor Specialty Pharmacists provide on-going support for members using specialty medications. Care includes helping members with convenient delivery options, medication coverage support, and complex condition management. You can contact the Maxor Specialty Pharmacy at **866.629.6779** for more information.

Specialty Drug Pre-Approvals

Specialty medications require pre-authorization from RxResults. Prescribing physicians should call **844.853.9400** or fax request to **855.586.3291** to begin the pre-authorization process.

SIH Employee Pharmacy at Herrin Hospital

If you're enrolled in the SIH health plan, you and your covered family members should consider filling your prescriptions at the SIH Employee Pharmacy (E-Pharmacy). It's convenient and you'll save money. At the Employee Pharmacy you are able to take advantage of lower copayments and prices. Depending on the medication and certain regulations, you may pick up a 30-or 90-day supply. Prescriptions are also available for pickup from the ScriptCenter located in the outpatient surgery lobby at Memorial Hospital of Carbondale (MHC). Prescriptions are filled by Herrin Hospital pharmacy and loaded into the ScriptCenter for you to pick up at your convenience.

Retail	(30-day supply)	(90-day supply)
Tier 1—Generic	$5	$12.50
Tier 2—Preferred Brand	$17.50	$43.50
Tier 3—Non-Preferred Brand	$30	$75

Location	Information
Herrin Pharmacy **618.351.8321**	▶ Monday-Friday: 8:00 a.m.–4:30 p.m. ▶ Saturday/Sunday: 8:00 a.m.–2:00 p.m. (pick-up only)
ScriptsCenter: Located at MHC **618.351.8321**	▶ Order your prescriptions from the Herrin Hospital pharmacy ▶ Create your ID and PIN at **ScriptCenter.com** ▶ Allow 24 hours for prescriptions to be filled

SIH Employee Wellness Program

SIH is committed to providing you with resources to support you with your Health and Wellbeing! The SIH Employee Wellness Program provides tools and resources to help you achieve and maintain a healthier lifestyle to help you be your best self! Visit your personal wellness portal at **sihwellness.com** to access wellness activities and program resources.

To avoid an increase of $250 in the SIH health plan premiums for 2026, you will need to complete various wellness activities in 2025.

- Employees (who are enrolled in the SIH medical insurance plan) need to complete an annual physical and recommended biometric screenings based on age and gender (required for both "Prevent Track" and "Manage Track" wellness initiatives). This requirement is due on September 1 each calendar year.
- Employees on the "Manage Track" need to complete health coaching with a member of the SIH Wellness team prior to December 15.

To manage your wellness activities, view your requirements and track your progress, visit **www.sihwellness.com**.

Contact Information

- Wellness website:
  - **www.sihwellness.com**
- Wellness phone:
  - **618.457.5200** ext. **67827**
- Wellness email:
  - **wellness@sih.net**
- Julie Neubig
  - Director of Total Rewards
  - **julie.neubig@sih.net**
  - **618.457.5200** ext. **67807**

To register on the Wellness Website, Follow These Steps:

Visit **www.sihwellness.com**

1. Click "Sign Up."
2. Enter your unique ID and date of birth. Your unique ID is the word "SIHS" followed by your employee ID number; for example, SIHS1234. For spouses, add "SO" at the end; example: SIHS1234SO.
3. Enter a valid email address. Note: employees and spouses cannot use the same email address.
4. Click "Agree," then visit the home page of ManageWell.

SIH Employee Wellness Health Coaching

Our coaching team includes professionals with diverse education backgrounds including a certified personal trainer, a registered dietitian, and a registered nurse. Your Health Coach can help you with one or more of the following:

- Stress management
- Nutrition
- Weight management
- Work-life balance
- Sleep
- Diabetes
- High blood pressure
- High cholesterol
- Smoking cessation
- Physical activity
- And more

Your health coach can provide you with the following free of charge as part of the coaching program:

- Glucometers
- Nicotine replacement
- Blood pressure monitors

Call to learn more: **618.457.5200** ext. 67827 or click **Contact Me About Coaching** on your wellness portal at **www.sihwellness.com**.

Dental Options

You have two dental options, a High plan and a Low plan, and they are administered by Cigna. Each option includes preventive, basic, major care, and orthodontic care. Our plans access the Cigna DPPO network. Keep in mind the best discounts on your services are received when you use an in-network provider to ensure you are not subject to balance billing. If you seek services from an out-of-network provider, please note you may be subject to balance billing, where a provider may bill you for the difference between what Cigna paid the provider and what the provider actually charged.

To locate an in-network provider, visit **www.cigna.com** (select Total Dental PPO) or call **800.244.6224**.

You can also call your current dental provider to ensure they are in Cigna's network. If you enroll family members in your dental option, you will be required to complete a coordination of benefits (COB). The plan administrator will mail you a packet containing the required COB form. Please complete and submit this form in a timely manner to avoid claim denials in the future.

Please note: if your spouse is also an employee of SIH, you will need to choose employee coverage under your own plan or spouse or family coverage under your spouse's plan. You cannot be enrolled in both.

SIH Dental Coverage	High Option (A)	Low Option (B)
Annual Deductible (per covered person for basic services)	$50	$100
Preventive Service (cleanings, fluoride, routine exams, X-rays)	100% coverage/no deductible	100% coverage/no deductible
Basic Services (fillings, extractions, root canal, etc.)	80% coverage after deductible	60% coverage after deductible
Major Services (bridges, dentures, inlays, crowns, etc.)	50% coverage after deductible	50% coverage after deductible
Annual Maximum Benefit (excluding orthodontic treatment)	$1,500	$1,250
Orthodontics (lifetime maximum benefit)	$1,500	$1,250

Dental Pricing

	Employee Monthly Contribution	Employee Cost Per Pay Period
Dental—High Option		
Employee Only	$38.40	$19.20
Employee + Spouse	$80.65	$40.33
Employee + Child(ren)	$69.13	$34.57
Employee + Family	$122.90	$61.45
Dental—Low Option		
Employee Only	$25.12	$12.56
Employee + Spouse	$52.76	$26.38
Employee + Child(ren)	$45.22	$22.61
Employee + Family	$80.38	$40.19

The dental plan documents are available online at benefits.sih.net. If you do not have access to a computer, printed copies are available upon request from Human Resources.

Vision

The SIH vision plan is administered by EyeMed and is available to all eligible full-time and part-time employees. Coverage and pricing can be reviewed below.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary		
	$10 copay	Up to $35
Frames		
	$0 copay; $120 allowance; 20% off balance over $120	Up to $50
Standard Plastic Lenses		
Single Vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $55
Standard Progressive Lens	$90 copay	Up to $40
Premium Progressive Lens	$90 copay; 20% off retail price less $120 allowance	Up to $40
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit and Follow-Up	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 copay; $120 allowance; 15% off balance over $120	Up to $92
Disposable	$0 copay; $120 allowance; plus balance over $120	Up to $92
Medically Necessary	$0 copay, paid-in-full	Up to $200
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Diabetic Care Services (Type 1 and Type 2 Diabetics)		
Office Service Visit—Up to (2) Services Per Benefit Year	Covered 100%, $0 copay	Up to $77
Retinal Imaging—Up to (2) Services Per Benefit Year	Covered 100%, $0 copay (Not covered if extended ophthalmoscopy is provided within 6 months)	Up to $50
Extended Ophthalmoscopy—Up to (2) Services Per Benefit Year	Covered 100%, $0 copay (Not covered if retinal imaging is provided within 6 months)	Up to $15
Gonioscopy—Up to (2) Services Per Benefit Year	Covered 100%, $0 copay	Up to $15
Scanning Laser—Up to (2) Services Per Benefit Year	Covered 100%, $0 copay	Up to $33

Vision Pricing

	Employee Monthly Contribution	Employee Cost Per Pay Period
Vision		
Employee Only	$5.68	$2.84
Employee + Spouse	$10.72	$5.36
Employee + Child(ren)	$11.27	$5.64
Employee + Family	$16.53	$8.27

The vision plan documents are available online at benefits.sih.net. If you do not have access to a computer, printed copies are available upon request from Human Resources.

Healthcare Flexible Spending Account

The Healthcare Flexible Spending Account (FSA) is a type of savings and spending/flexible spending account that allows you to reimburse yourself with pretax dollars for eligible out-of-pocket healthcare costs. You can use the healthcare FSA to cover eligible healthcare expenses not covered by your health, dental, and/or vision plans. When you do, you don't pay federal income taxes on the money in your account.

You can set aside $60 to $3,300* for the 2025 plan year to cover eligible expenses during the year. Your contributions come out of your pretax pay in equal installments each pay period. You or your family members do not have to be a member of any medical, dental, or vision option to enroll in the healthcare FSA. Money is available as of the plan start date with the Healthcare Flexible Spending Account.

FSAs have a "use it or lose it" policy, which means you forfeit any amounts unused and not reimbursed for services received during the plan year. You may use what you set aside for the plan year for services up to March 15th of the following year. You must file your claims by March 31st of the following year. The FSA administrator is Allegiance and provides convenient ways for you to access your account: debit card, direct deposit, and online viewing.

Examples of Eligible Expenses

Some Eligible Expenses	Some Expenses Not Eligible
Money Can Be Set Aside for	The IRS Lists These Non-Eligible Expenses
▶ Deductibles and copayments	▶ Cosmetic procedures
▶ Dental and vision care expenses	▶ Your contributions for outside health or life insurance
▶ Prescription drugs and over-the-counter medications	▶ Employer health premiums of any kind
▶ Chiropractic visits	▶ Procedures or expenses not medically necessary
▶ Doctor prescribed weight loss programs	▶ Weight loss programs not prescribed by a doctor

* Subject to change each year based upon IRS maximum limits.

For more information and other tools and resources, log on to **www.AllegianceFlexAdvantage.com** or call **855.999.1052**.

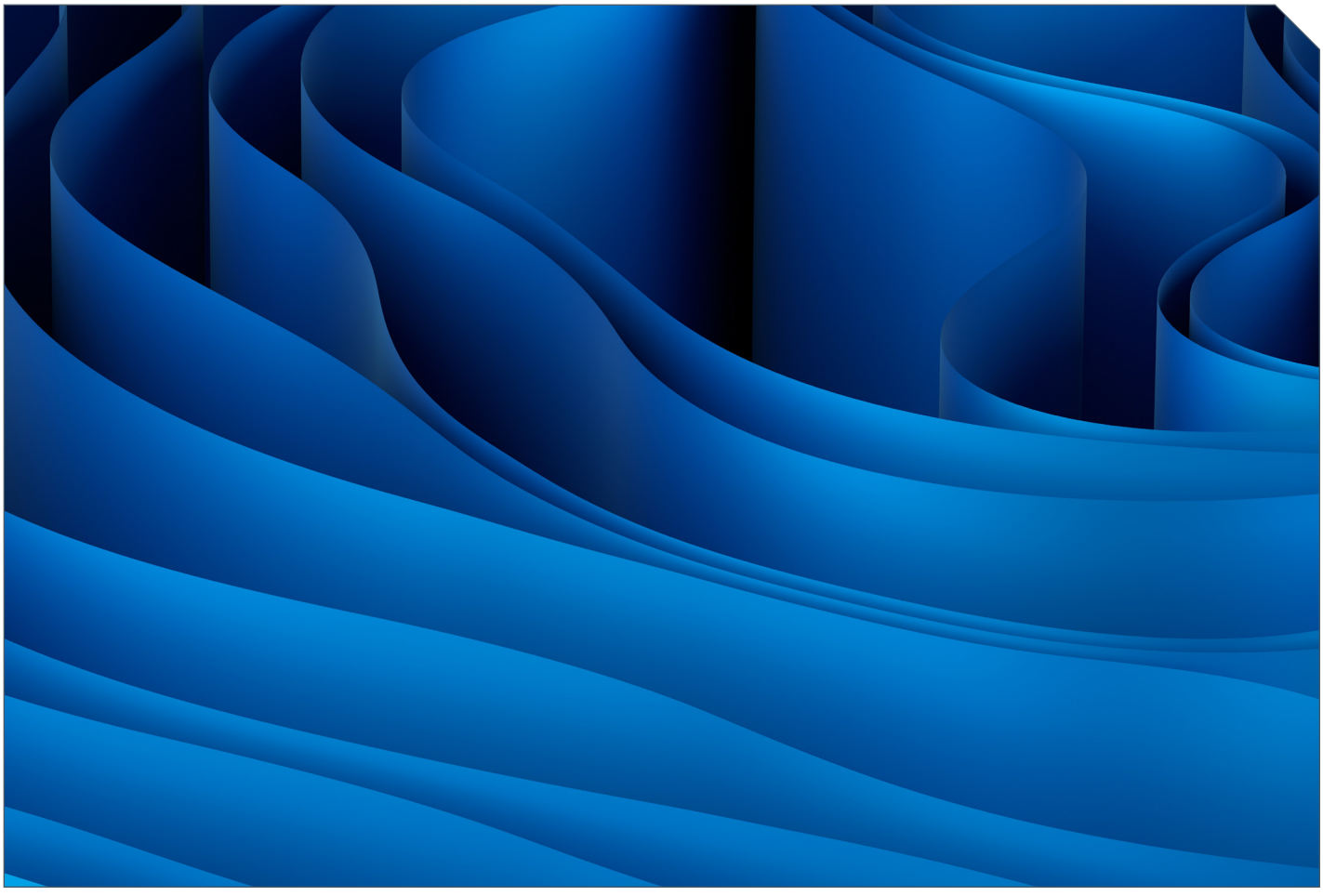
Dependent Care Flexible Spending Account (FSA)

The Dependent Care Flexible Spending Account (FSA) is a type of savings and spending, flexible spending account that allows you to reimburse yourself with pretax dollars for eligible expenses you pay to take care of a qualified dependent.

Qualifying dependents include:

- Children under age 13 you claim as dependents on your tax return
- Anyone age 13 or older who lives with you at least eight hours a day and needs supervised care, such as an elderly parent or a child or spouse with a disability

Based on Your Tax Status...	For the Plan Year, You Can Set Aside...
If single or married filing jointly	$60 to $5,000
If married filing jointly and your spouse's employer offers a dependent care account	Up to $5,000 in total between the two accounts
If married filing separate returns	Up to $2,500



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

Life insurance provides protection for your family in the event you are no longer able to provide for them. At SIH, full-time employees are provided 1× your salary FREE as a Basic Life and Accidental Death and Dismemberment Benefit.*

Beneficiary Information

Be sure to keep your beneficiary updated in the event you pass away to ensure your life insurance is paid to the intended person(s).

Some common beneficiary choices are:

- **Primary beneficiary**—the person or persons named will receive the benefit
- **Contingent beneficiary**—if the primary beneficiary is no longer living, the benefit is paid to this person

Supplemental Employee Life Insurance

You may select any of the life insurance options when you are first eligible or as a new hire. Benefit amounts between 1 and 4 times your base annual earnings, up to a maximum of $1,000,000 are available.* Medical underwriting may be required. The Basic Life coverage amount is included in the $1,000,000 coverage maximum for full-time employees. Eligible part-time employees may also elect this coverage.

If you purchased at least 1 time your salary when you were first eligible, you can increase your life insurance one step during open enrollment without medical underwriting, not to exceed $300,000. If the next step exceeds $300,000, you will be required to submit proof of good health for any amount over.

Benefit Reductions

- At age 70, the original benefit is reduced to 67%
- At age 75, the original benefit is reduced to 50%

Basic Life and AD&D is insured through New York Life Group Benefit Solutions.

* This represents what the majority of full-time employees are provided.

Under IRS regulations, employer-provided group term life insurance in excess of $50,000 is taxable. For more information, visit **https://www.irs.gov/government-entities/federal-state-local-governments/group-term-life-insurance**.

Changes in Amount of Insurance

Increases and decreases in the amount of insurance because of changes in age are effective on the January 1 coinciding with or next following the date of the change. Increases and decreases in the amount of insurance because of changes in class or earnings (if applicable) are effective on the date of the change.

Voluntary Spouse Life

All employees enrolled in Supplemental Employee Life Insurance and have a dependent spouse listed in the dependent information section of the online benefit enrollment may elect and pay for Voluntary Spouse Life coverage. Spouses may be enrolled in either a $5,000, $10,000, $20,000, or a $40,000 benefit.

If you select spouse life coverage when you are first eligible, you can increase coverage one step each year during open enrollment without medical underwriting.

Your family member's coverage may not exceed your own coverage.

The employee is always the beneficiary of this plan.

Voluntary Spouse Life is insured through New York Life Group Benefit Solutions.

Please note: if your spouse is an employee of SIH and carries Supplemental Employee Life Insurance, you are not eligible to purchase this coverage, as it will be considered duplication and the insurance carrier will not pay on both policies in the event of a life claim.

Confirm your spouse's elections before enrolling in these plans.

Voluntary Child Life

All employees enrolled in Supplemental Employee Life Insurance and have a dependent child(ren) listed in the dependent information section of the online benefit enrollment may elect and pay for Voluntary Child Life coverage. Children may be enrolled in either a $2,500, $5,000, $10,000, or a $20,000 benefit. Coverage is guaranteed issue. The maximum benefit for a dependent child who is less than 6 months old is $1,000.

The employee is always the beneficiary of this plan.

Voluntary Child Life is insured through New York Life Group Benefit Solutions.

Please note: if your spouse is an employee of SIH and carries Voluntary Child Life Insurance, you are not eligible to purchase this coverage, as it will be considered duplication and the insurance carrier will not pay on both policies in the event of a life claim.

CONFIRM YOUR SPOUSE'S ELECTIONS BEFORE ENROLLING IN THESE PLANS.

Supplemental AD&D Options

The Voluntary Accidental Death and Dismemberment (AD&D) plan pays an additional benefit to your life insurance in the event you die or suffer certain injuries as a result of an accident. The full amount is payable for accidental death, or a percentage of your coverage amount is payable for other covered losses. Full-time and eligible part-time employees are able to purchase additional amounts of coverage on themselves, as well as family members. If you do purchase coverage for your eligible family members, their coverage will be a percentage of the amount you choose for yourself. See the table below for more details. Benefit amounts between 1× and 4× your base annual earnings, up to a maximum of $1,000,000 are available.* The Accidental Death and Dismemberment coverage provided FREE to full-time employees is included in the $1,000,000 coverage maximum.

Family AD&D Coverage	
Spouse Only	60% of the amount you select
Child(ren) Only	15% of the amount you select (for each child)
Spouse and Child(ren)	50% (for your spouse) and 10% (for each child) of the amount you select

Loss	Percent of Coverage Amount
Life	100%
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Hand and One Eye	100%
One Foot and One Eye	100%
Speech and Hearing	100%
One Hand or One Foot or One Eye	50%
Speech or Hearing	50%
Thumb and Index Finger on Same Hand	25%

* This represents what the majority of employees are provided.

Confirm your spouse's elections before enrolling in these plans.

Benefit Reductions

- At age 70, the original benefit is reduced to 67%
- At age 75, the original benefit is reduced to 50%

Voluntary Accidental Death and Dismemberment is insured through New York Life Group Benefit Solutions.

Changes in Amount of Insurance

Increases and decreases in the amount of insurance because of changes in age are effective on the January 1 coinciding with or next following the date of the change. Increases and decreases in the amount of insurance because of changes in class or earnings (if applicable) are effective on the date of the change.

Please note: if your spouse is an employee of SIH and carries Voluntary Accidental Death and Dismemberment Family Insurance, you are not eligible to purchase this coverage, as it will be considered duplication and the insurance carrier will not pay on both policies in the event of a claim.

Short Term Disability

This coverage is an important part of your financial security should you become disabled due to an accident or illness and are unable to work for a period of time. Short Term Disability is FREE for full-time employees after one year of full-time service. Coverage begins on the first of the month following one year of full-time service.

After a 5-calendar day/40-hour elimination period, 60% of your weekly pre-disability earnings up to $10,000 per week maximum is paid directly to you in the event of a disability claim approval up to a 90-day duration. You may choose to utilize your ETO to supplement the remaining 40% of your pay.

Short Term Disability is administered by our SIH Leave and Absence department.

How to File a Short Term Disability or FML Claim

SIH's leave policy requires that all employees file leave and report within three (3) days of the leave start date for continuous leaves and 24 hours for intermittent leaves.

To file a claim, visit the self-service portal at **hub.sih.net/leaveportal**. You can also call **618.457.5200** ext. **67828** or email **LOA@sih.net**.

Long Term Disability and Buy-Up

Long Term Disability

Long Term Disability protection helps replace a portion of your income for the "long term," resulting from a covered injury or sickness. Long Term Disability is FREE for full-time employees after one year of full-time service. Coverage begins on the first of the month following one year of full-time service.

After a 90-calendar day elimination period, 50% of your pre-disability earnings up to a monthly maximum of $10,000 is paid to you in the event of a disability claim approval up to the benefit duration.*

Long Term Disability is administered by New York Life Group Benefit Solutions.

* This represents what the majority of employees are provided.

Long Term Disability—Buy-Up

You can select an additional 10% of Long Term Disability Coverage for a total of 60% of covered pre-disability earnings. Total monthly earnings will not exceed $10,000.

Selection for the 10% Buy-Up must be made when you first become eligible. If you are selecting coverage during open enrollment, then medical underwriting is required.

Long Term Disability Buy-Up Coverage is administered by New York Life Group Benefit Solutions.

Voluntary Benefits through Allstate Benefits

Please note: if your spouse is also an employee of SIH, you will need to choose employee coverage under your own plan or spouse or family coverage under your spouse's plan. You cannot be enrolled in both.

Group Critical Illness Coverage

Group Critical Illness coverage helps offer financial support if you are diagnosed with a covered critical illness. You select the benefit coverage amount based on your individual need and your budget. There are two benefit plan options from which to choose:

- Plan 1: $10,000
- Plan 2: $20,000

If you have covered family members, these plans can also provide cash benefits for them. Covered diagnoses include but are not limited to the following:

- Heart attack
- Stroke
- End Stage Renal Failure
- Complete Blindness
- Advanced Alzheimer's Disease
- Major Organ Transplant
- Invasive Cancer

Group Hospital Indemnity Medical Coverage

Indemnity Medical insurance pays a cash benefit for hospital confinement. This benefit is payable directly to you and can keep you from withdrawing money from your personal bank account for hospital-related expenses. You can use the money toward deductibles, copays, premiums, and even to help cover your daily living expenses. Base benefits include the following:

Benefit	Description
First Day Hospital Confinement	$1,200
Daily Hospital Confinement	$200 per day*
Hospital Intensive Care	$200 per day*

* Max 10 days per hospital confinement

Group Accident Coverage

Group Accident coverage pays you cash benefits for covered accidents and includes coverage for a variety of occurrences, such as: hospital confinement, physician treatment, dislocation or fracture, ambulance services, physical therapy, and more.

Following are a few highlights of the plan:

- $200 for Emergency Room Services ($150 for Urgent Care or Accident Physician's Treatment)
- $1,000 for Initial Hospital Confinement
- $200 for Daily Hospital Confinement
- $300 for X-ray
- Up to $6,000 for Dislocation or Fracture

Please note: if your spouse is also an employee of SIH, you will need to choose employee coverage under your own plan or spouse or family coverage under your spouse's plan. You cannot be enrolled in both.

Refer to Allstate Benefits brochure for full description of benefits, limitations, and exclusions.

This is a brief overview of the benefits available under the group policies underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). For additional information, including exclusions and limitations, you may contact your Allstate Benefits Representative. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, a subsidiary of the Allstate Corporation.

Group Term to Age 100 Life Insurance

You choose the coverage that's right for you and your family. With planning, the death benefit can pass to your beneficiaries free from state or federal estate taxes.* You choose the death benefit amount to leave behind. Premiums are affordable and remain level to age 100 unless you make changes to your coverage. Premiums are conveniently payroll deducted. Guaranteed minimum death benefit is level for 5 years; current non-guaranteed death benefit is projected to remain level to age 100. Benefit options available are $30,000, $45,000, $60,000, and $75,000.

Evidence of Insurability is required for any employee over 65.

All employees enrolled in Term to Age 100 Employee Life Insurance and who have a dependent spouse listed in the dependent information section of the online benefit enrollment may elect and pay for Group Term to Age 100 Spouse Life Insurance. The spouse guaranteed issue option is $30,000. Evidence of Insurability will be required for non-working spouses and applicants over age 65.

* Consult with your tax advisor for specific information

Children's Term Rider

All employees enrolled in Term to Age 100 Employee Life Insurance and who have a dependent child listed in the dependent information section of the online benefit enrollment may elect and pay for the Children's Term Rider. The Child(ren) rider is $20,000.

Allstate Benefits Critical Illness, Hospital Indemnity, and Accident products cannot pay benefits to you if you have coverage through Medicaid. If you are covered by Medicaid, you should not enroll in these products. If only your child or children are eligible for Medicaid benefits, you may still benefit from the Allstate products, but you should not enroll your child(ren).

Employee Assistance Program (Personal Assistance Services)

SIH offers eligible employees access to its Employee Assistance Program. This program is 100% free to SIH employees and their families. This program is administered by Personal Assistance Services (PAS). Personal Assistance Services (PAS) provides you with a wealth of confidential, professional services that can help you address challenges and strengthen your work and home life. PAS services are free. Should your PAS consultant suggest a referral to a specialist or longer-term care provider, services outside of PAS are your financial responsibility. Your PAS consultant will assist you in arranging for ongoing services, if needed.

If you are a full-time, part-time, or per diem employee, you and your eligible dependents can receive PAS' services. This is a pre-paid benefit funded by SIH.

How Are Services Accessed?

There are many ways to access PAS' services. You can contact a PAS Client Services Specialist by phone at **800.356.0845**. You can also access their website by visiting **www.mypaseap.com** and using the organization code **SIH**.

PAS provides two free mobile apps as well, RxWell and eM Life. Download the apps through your mobile device to access additional information.

What Services Are Provided?

PAS' confidential and free services include:

- Certified financial counselors
- Attorneys
- Elder care managers
- Child care specialists
- Certified child development and parenting professionals
- Organization and time management specialists
- Career and retirement coaches
- Tobacco cessation coaches
- Master's level licensed counselors
- Registered and licensed dietitians
- Life and health coaches
- And more

Along with counseling services with a PAS master's level licensed counselor, counselors may be accessed in-person, telephonically, or by tele-video. Examples of services include:

- Marital counseling/relationship strengthening
- Depression and/or anxiety
- Work and life transitions and balancing
- Addiction
- Domestic safety
- And more

Retirement Savings Plan

SIH Retirement Savings Plan is a retirement savings plan designed to allow eligible employees to save and invest through a salary contribution. Read these highlights to learn more about our Plan. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

Eligibility Enrollment

You are eligible to participate in the Plan on the first day of the month coinciding with or following your date of employment. You are eligible to contribute if you are full-time, part-time, per diem or temporary. SIH Retirement Savings Plan is an automatic enrollment plan. If you have not made an affirmative election to contribute or opt out within 30 days after your first pay period, you will be automatically enrolled to contribute 5% of your pretax compensation. You may change your deferral amount or opt out by accessing your Empower Retirement account at **empowermyretirement.com** or by calling **833.SIH.401K** (**833.744.4015**). You may also schedule an appointment to discuss your options at **sih.empowermytime.com/#/**.

Automatic Annual Increase

If you are contributing less than 10% pretax, your pretax contribution rate will be increased according to the table below. If your pretax contribution rate is at 10% or higher, your contribution rate will not be affected. The automatic contribution rate increases only affect your pretax contributions. Participants making only Roth contributions or a combination of pretax and Roth contributions in which the pretax contribution is less than 10% will have their pretax contribution rate automatically increased as noted below. Participants who are contributing a pretax flat dollar amount will not be affected by these changes.

Pretax Contribution Rate	Pretax Contribution Rate Increase	Effective Date
0%–4%	5%	September
5%–9%	1% each year until it reaches 10%	September

Your Contributions

In 2025, the total employee contribution limit to all 401(k) plans for those under 50 will be $23,500*. The catch-up contribution limit is $7,500, so if you're 50+, your 401(k) employee contribution limit will be $31,000 in 2025. If you are aged 60-63 by the end of 2025, your catch-up contribution will be $11,250.

Before-Tax and Roth Contributions

You may designate your 401(k) contribution as pretax or Roth or a combination of the two.

Pretax contributions are made with dollars before taxes are paid. If you believe that your tax bracket will be lower in retirement, you may pay less in taxes at withdrawal by contributing on a pretax basis. You will pay ordinary income tax on your contributions and earnings at withdrawal.

Roth contributions are made with after-tax dollars. If you believe your tax bracket will be higher in retirement, you may pay less by paying taxes before your contributions are deposited to your 401(k) account. You will not pay ordinary income tax at withdrawal on the investment earnings with a qualified distribution.**

* Subject to change each year based upon IRS maximum limits.

** Subject to requirements: Roth contributions must have been made in your account for at least five years and the money withdrawn after you have reached age 59½, become disabled or died. If a distribution is not qualified, the earnings are taxed as ordinary income and may be subject to early withdrawal penalties.

Employer Contributions

Currently, SIH matches 50% of your contribution up to the first 5% of eligible compensation. You are eligible for this Employer Match contribution into the Plan the first of the month following your completion of 1,000 hours of service within 12 consecutive months commencing with your date of hire and during any subsequent Plan Year. Thereafter, in order to receive a Matching Contribution for a subsequent Plan Year, you must have completed at least 1,000 hours of service during the prior Plan Year. A Matching Contribution is not guaranteed each Plan Year. The amount of the Matching Contribution, if any, will be determined under a matching formula established by SIH for each Plan Year.

SIH may provide for a Basic contribution (profit sharing) in an amount of 1.5% of your eligible compensation. To be eligible for the profit sharing contribution into the Plan, you must complete 1,000 hours of service after one calendar year. You must be employed on the last day of the last pay period of the calendar year to be eligible.

Medicare Basics

Healthcare expenses in retirement could be a huge expense. It's important to have a solid understanding of Medicare basics, including costs and benefits. We have resources at SIH to help you better understand Medicare and how it affects your retirement planning. Use the contact information below to take advantage of Medicare counseling.

Contact Information

Christine Thompson, Medicare Counselor
Ext. **67856**
christine.thompson@sih.net

Vesting Schedule

Vesting refers to the percentage of your account you are entitled to receive upon the occurrence of a distributable event. The value of your contributions (including rollovers from previous employers), Matching Contributions, and any earnings they generate are always 100% vested. The value of Basic contributions to the Plan and any earnings they generate are vested as follows:

Years of Service Vested	Percentage of Employer Contributions
Less than 3 years	0%
3 years	100%

Beneficiary

You must select a beneficiary for your account. You can view or change your beneficiary information at any time by logging in to your account at **empowermyretirement.com**. You should check this information periodically to make sure it is up to date. If you are married, federal law says your spouse is automatically the beneficiary of your 401(k) account. You should still complete the beneficiary information with your spouse's information for the record. If you want to name a beneficiary who is someone other than your spouse, your spouse must sign a notarized waiver. If you are single, you can name whomever you choose as a beneficiary.

If your minor children are your beneficiaries, consider this carefully.

You may be eligible for withdraws, rollovers, and loans. Call the Empower Retirement Service Center or visit your online account at **empowermyretirement.com** for eligibility information.

Additional Benefits

Earned Time Off (ETO)

All employees begin accruing ETO immediately upon their date of hire. Full-time and part-time employees with an FTE of 0.5 and greater, there is no additional accrual and no payment for any ETO hours over the maximum of 544 hours.

Per diem and part-time employees with an FTE below 0.5 accrue ETO based on the number of hours worked and not to exceed 40 hours per week. There is no additional accrual and no payment for any ETO hours over the maximum of 40 hours.

ETO can be used for the following:

- Vacation
- Personal time
- Illness
- Any non-worked time including holidays

Holidays

SIH recognizes the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- The Friday after Thanksgiving
- Christmas Day

Employees who do not work a holiday must use ETO. Employees who work on a holiday receive 1.5 times their hourly pay.

Tuition Assistance

SIH encourages its employees to pursue educational opportunities which can assist their personal and professional growth, and could also benefit SIH in meeting its mission. It is available for part-time and full-time employees who work at least 32 hours per pay period.

Reimbursement amounts do not exceed $130 per credit hour for any undergraduate or graduate course, with a maximum of 27 credit hours per calendar year. Full-time employees receive 100% reimbursement within the limits for credit hour costs. Part-time employees budgeted to work at least 32 hours per pay period are reimbursed on a percentage basis of their tuition and fee costs. Please view policy SY-HR-205 for more details.

Employees Helping Employees (EHE)

SIH offers financial assistance for employees under certain hardship circumstances provided by the Mission & Values Team. Receive up to $500 to help you during these times of hardship. A $900 annual maximum distribution applies. An application for assistance to be reviewed by the committee is also required. An application can be located at **hub.sih.net**.

Service Awards

SIH greatly values the service of all employees, but gives special recognition to those who have served for longer periods of time.

- After five years of service, employees will be invited to the Service Award event
- After ten years of service, employees will receive service award payments; the award is a sum of a per year dollar multiplied by the total number of years of service and the maximum payout is $900; refer to the chart below

Years of Service	Calculation	Award Amount
10 Years	10 years × $10 per year	$100.00
15 Years	15 years × $15 per year	$225.00
20 Years	20 years × $20 per year	$400.00
25 Years	25 years × $25 per year	$625.00
30 Years	30 years × $30 per year	$900.00
35+ Years	30 year (maximum)	$900.00

More information about these provisions, as well as other system policies, may be found on the intranet Hub at **hub.sih.net**. For information about department specific policies/practices, please contact your supervisor.

Glossary of Health Coverage and Medical Terms

This glossary defines many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in our plan or health insurance policy. Some of these terms also might not have the same meaning when used in our policy or plan, and in any case, the policy or plan governs (see your Summary of Benefits and Coverage for information on how to get a copy of our policy or plan document).

ALLOWED AMOUNT

This is the maximum payment the plan will pay for a covered healthcare service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

APPEAL

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

BALANCE BILLING

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

CLAIM

A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare provider to your health insurer or plan for items or services you think are covered.

COINSURANCE

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

COPAYMENT

A fixed amount (for example, $20) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

COST SHARING

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

DEDUCTIBLE

An amount you could owe during a coverage period (usually one year) for covered healthcare services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible.)

DIAGNOSTIC TEST

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

DURABLE MEDICAL EQUIPMENT (DME)

Equipment and supplies ordered by a healthcare provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

EMERGENCY MEDICAL CONDITION

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention, you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

EMERGENCY MEDICAL TRANSPORTATION

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea.

EMERGENCY ROOM CARE/EMERGENCY SERVICES

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

EXCLUDED SERVICES

Healthcare services that your plan doesn't pay for or cover.

FORMULARY

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

HEALTH INSURANCE

A contract that requires a health insurer to pay some or all of your healthcare costs in exchange for a premium. A health insurance contract may also be called a "policy "or "plan."

HOME HEALTHCARE

Healthcare services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed healthcare providers. Home healthcare usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

HOSPICE SERVICES

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITALIZATION

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

HOSPITAL OUTPATIENT CARE

Care in a hospital that usually doesn't require an overnight stay.

IN-NETWORK COINSURANCE

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

IN-NETWORK COPAYMENT

A fixed amount (for example, $20) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

MAXIMUM OUT-OF-POCKET LIMIT

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

MEDICALLY NECESSARY

Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

NETWORK PROVIDER (PREFERRED PROVIDER)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

ORTHOTICS AND PROSTHETICS

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

OUT-OF-NETWORK COINSURANCE

Your share (for example, 40%) of the allowed amount for covered healthcare services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

OUT-OF-NETWORK COPAYMENT

A fixed amount you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

OUT-OF-NETWORK PROVIDER (NON-PREFERRED PROVIDER)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

OUT-OF-POCKET LIMIT

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for healthcare costs. This limit never includes your premium, balance-billed charges or healthcare your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

PHYSICIAN SERVICES

Healthcare services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

PLAN

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain healthcare costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

PREAUTHORIZATION

A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

PREMIUM

The amount that must be paid for your health insurance or plan.

PRESCRIPTION DRUG COVERAGE

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

PRESCRIPTION DRUGS

Drugs and medications that by law require a prescription.

PREVENTIVE CARE (PREVENTIVE SERVICE)

Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

PRIMARY CARE PHYSICIAN

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of healthcare services for you.

PRIMARY CARE PROVIDER

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of healthcare services.

PROVIDER

An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

RECONSTRUCTIVE SURGERY

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

REHABILITATION SERVICES

Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and or outpatient settings.

SCREENING

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

SKILLED NURSING CARE

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

SPECIALIST

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

SPECIALTY DRUG

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (USUAL, CUSTOMARY, AND REASONABLE)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.
The UCR amount sometimes is used to determine the allowed amount.

URGENT CARE

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Southern Illinois Healthcare

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Southern Illinois Healthcare About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM SOUTHERN ILLINOIS HEALTHCARE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southern Illinois Healthcare and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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

2. Southern Illinois Healthcare has determined that the prescription drug coverage offered by the Southern Illinois Healthcare Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

   Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

   Enrolling in Medicare—General Rules
   As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

   Late Enrollment and the Late Enrollment Penalty
   If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

   If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Southern Illinois Healthcare Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Southern Illinois Healthcare Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Southern Illinois Healthcare Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Southern Illinois Healthcare prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 618-457-5200. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southern Illinois Healthcare changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.

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

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

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

Date:	October 15, 2024
Name of Entity/Sender:	Human Resources
Contact—Position/Office:	Human Resources
Address:	2 Nutrition Plaza Carbondale, IL 62901
Phone Number:	618-457-5200

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES
SOUTHERN ILLINOIS HEALTHCARE
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Southern Illinois Hospital Services Employee Benefit Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Southern Illinois Healthcare is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

The Plan's Deputy Privacy Official(s) is/are:

Marcia Matthias
Corporate Director Health
618-457-5200

Effective Date

The effective date of this notice is: October 15, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

SOUTHERN ILLINOIS HEALTHCARE EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Human Resources
Human Resources
618-457-5200
2 Nutrition Plaza
Carbondale, IL 62901

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Human Resources
2 Nutrition Plaza
Carbondale, IL 62901
618-457-5200

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Southern Illinois Healthcare Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The Southern Illinois Healthcare Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Human Resources
2 Nutrition Plaza
Carbondale, IL 62901
618-457-5200

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Southern Illinois Healthcare Wellness Program is a voluntary wellness program available to All employees and their spouses enrolled in the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in your personal wellness portal at sihwellness.com.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 618-457-5200 or .

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as . You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 618-457-5200.

ILLINOIS ESSENTIAL HEALTH BENEFIT NOTICE

Employer Name:	**Southern Illinois Healthcare**
Employer State of Situs:	**Illinois**
Name of Issuer:	**Allegiance**
Plan Marketing Name:	**Medical Plan**
Plan Year:	**2025**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone anchored hearing aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (vasectomy men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 - 25	Yes
17	Reconstructive Surgery		Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)		Pgs. 18 & 31	Yes

21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage		Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31 - 32	Yes
36	Mammography - Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

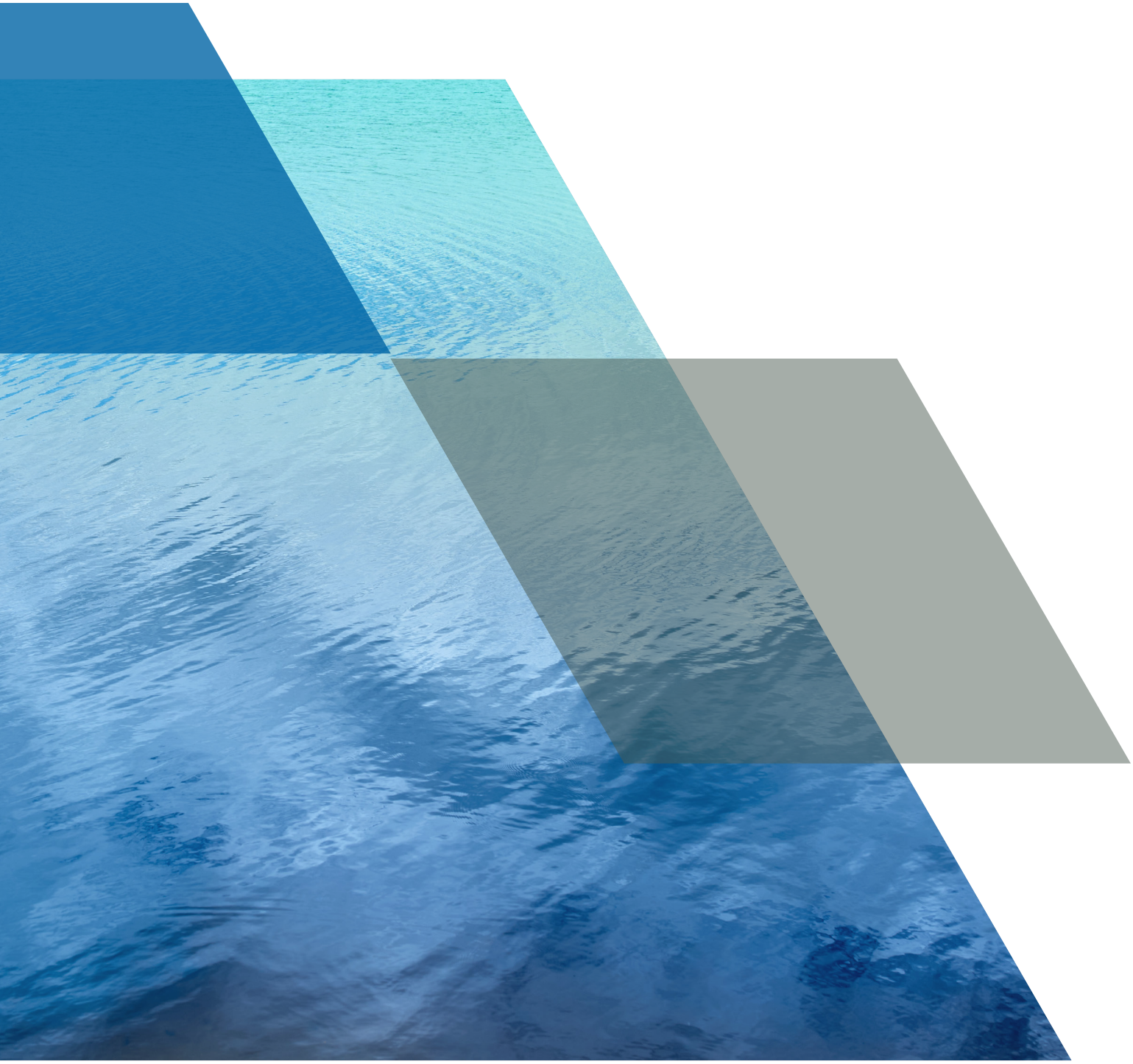
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor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

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

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

Notes

Notes



This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

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