TotalRewards My Benefits

2024

Team Member Guide to Benefits Enrollment

Franciscan Missionaries of Our Lady HEALTH SYSTEM

FMOLHS 2024 Benefits Guide

Inside this guide, you'll find:

- Your 2024 benefit choices and premiums
- Medical plan comparisons
- Highlights of the FMOLHS Total Rewards Program
- Steps to enroll
- Tools and resources

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See page 49 for more information concerning Medicare Part D coverage.

Let's get started

What's in this Guide and How to Use It

Contents

How to Use this Guide

- Click the Home icon on the bottom left of each page to return to this page.
- Use the Menu on the left of each page to move between sections.
- When you see a link in the text, click to go directly to another page or website to find out more.
- Use the Next and Previous arrows on each page to move within sections.

Total Rewards Program

Just as our team members are more than their job descriptions, our rewards program is more than compensation and benefits. Our Total Rewards Program is inspired by our team members and what's important to you. We know priorities can change and we are committed to offering flexible and competitive offerings to care for you and your family, during every stage of life.

Our program is unique to our organization and combines six distinct areas that you can use to meet your individual and family needs:

- My Purpose
- My Personal Growth & Development
- My Compensation
- My Recognition
- My Benefits
- My Health & Well-Being

This guide will help you understand more about the benefit coverage options and rewards available to you as a team member of FMOLHS.

Enrollment

Eligibility & Dependent Eligibility

All active full-time (0.8 to 1.0 FTE) and part-time (0.5 - 0.79 FTE) team members are eligible for benefits with FMOLHS.

As a benefits-eligible team member, you and your eligible dependents may participate in the FMOLHS benefits program. Your eligible dependents include:

- Your legal spouse
- Your dependent children up to age 26 (includes stepchildren, legally-adopted children or children placed with you for adoption, foster children and grandchildren for whom you have legal custody)
- Your dependent child, regardless of age, provided they are incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your health plan to continue coverage past age 26

When you add dependents to your core benefits coverage, you'll need to provide documentation that each dependent meets the eligibility requirements (i.e., marriage certificate, birth certificate, court order, etc.). Upload the required documents in **Oracle Employee Self Service** before your enrollment deadline. The documents shown here are required in our verification process.

Upload dependent verification documents in Oracle Employee Self Service under Benefits.

Spouse	Natural Child*	Stepchild* (Requires spouse & child verification documents)	Adopted Child/Child Placed for Adoption*	Foster Child*	Grandchild*
Marriage certificate **AND** • Current or previous year tax return face sheet **OR** • Proof of current joint ownership (mortgage, bank account, rental agreement, auto insurance, etc.)	Birth certificate; for newborns, birth letter from hospital	Birth certificate **AND** verification of current marriage between team member and natural parent (see spouse verification requirements)	Adoption certificate/ placement letter from court or adoption agency for pending adoptions	Proof of legal custody, such as a court order	Proof of legal custody, such as a court order **AND** Copy of current tax return that identifies grandchild as a taxable dependent

**Less than age 26 regardless of marital or student status*

FMOLHS reserves the right to audit dependent verification documents at any time.

Enrollment

When Coverage Begins

Coverage begins on the first of the month after 30 days of your new hire/new eligibility date.

Making Benefit Changes During the Year

The benefits you elect during your enrollment period will be effective the first of the month after 30 days of your new hire/new eligibility date. After your enrollment period ends, you may not change or cancel your benefit elections during 2024 unless you experience a qualifying life event. Qualifying life events include, but are not limited to these changes:

- Your FTE status from part-time to full-time or full-time to part-time results in a significant increase or decrease in your premiums (medical and dental)
- Your legal marital status changes (marriage and divorce)
- There's an increase or decrease to the number of your dependents (birth, adoption or child is no longer an eligible dependent)
- Your spouse's employment status results in a loss or gain of coverage
- Your employment that results in a loss or gain of coverage
- Entitlement to Medicare or Medicaid*

**If you become eligible for or lose coverage under Medicaid or a state child health plan, you must enroll or terminate coverage within 60 days.*

Changes must be made in Oracle Employee Self Service within 30 days of your qualifying life event (For example, if you get married on March 1st , you must enroll no later than March 30th).

Enrollment

How to Enroll

You must enroll in **Oracle Employee Self Service** within 30 days of new hire/ new eligibility date.

Be sure you review your Oracle account prior to enrolling and ensure your time zone is set to Central time zone versus the default of UTC time zone. Not updating your time zone may impact your ability to enroll on the last day of the enrollment period.

We have tools and resources to help you choose your benefits! See page 8.

1. **Consider Your Choices**
   Review this guide to understand your options and consider the coverage that fits for you and your family in 2024.
2. **Review Your Personal Information**
   Make updates, if needed, and remember to make sure your Oracle account is set to Central time zone.
3. **Enroll Online from Work or Home**
   eqtm.login.us2.oraclecloud.com
4. **Log in with Your Username and Password**
   - Click the **Me** tab
   - Click the **Benefits** tile

   Note: Before starting your enrollment, review My Benefit Resources Card for your benefit options and important notices
   - Click the **Start Enrollment** button
5. **Add Your Dependents and Beneficiaries**
   - Complete all required fields for each new dependent or beneficiary
   - Upload dependent verification documents to **Oracle Employee Self Service** under Benefits/My Documents
6. **Review Your Dependent Child's Eligibility for Coverage**
   - Core benefits (health, dental and vision) – eligible to age 26 regardless of marital or student status
   - Voluntary life benefits – eligible to age 26 regardless of marital status or student status
   - Voluntary accident and critical illness benefits – eligible to age 26 regardless of marital status or student status
7. **Save and Print Your Elections!**
   If your benefit elections are properly completed and saved, you'll receive a "Your benefit elections were saved" message on the screen. **If you do not receive that confirmation message, your elections were not properly completed. You must complete the election process again before your enrollment deadline.**

Go to My Benefits card to view and print a copy of your elections. You must have a copy of your 2024 benefit elections to report an enrollment problem.

Enrollment

Tools to Help You Choose

Tour the Virtual Benefits Fair

During your enrollment period, you'll have 24/7 online access to benefits vendors and resources. To support you in your benefits decision-making, the Virtual Benefits Fair allows you to:

- Watch short benefits videos at the Video Library booth
- Learn about programs to help you with stress management, mindfulness and well-being
- Connect with our medical, dental, prescription drug and voluntary benefit plan representatives through email or phone

The site is available anytime from any device. Visit **virtualfairhub.com/FMOLHSbenefits**.

Enrolling in an FMOLHS Medical Plan? Register for My Health Toolkit

You'll have instant access to your benefits information, insurance cards, claims and covered local providers when you download the My Health Toolkit mobile app (**MyHealthToolkitLA.com/links/FMOLHS**). This free app is available 24/7 from your mobile device.

Sign up to get started:

1. Go to **MyHealthToolkitLA.com/links/FMOLHS** and select Register Now.
2. Enter the number on your Blue Cross Blue Shield membership card and your date of birth. If you don't have your membership card, you can enter your Social Security number.
3. Choose a username and password.
4. Enter your email address. You can choose to go paperless.

Enrollment

Your BCBS Membership Card

Your Blue Cross Blue Shield (BCBS) membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times by downloading your digital membership card to keep on your smartphone. It's so convenient!

Your digital card features the same information as your plastic card, including your deductible and out-of-pocket maximum. With the digital card, you can:

- View your card on your smartphone, tablet or computer
- Email the card to your spouse, child, doctor's office or pharmacy
- Print the card and use it like the plastic version

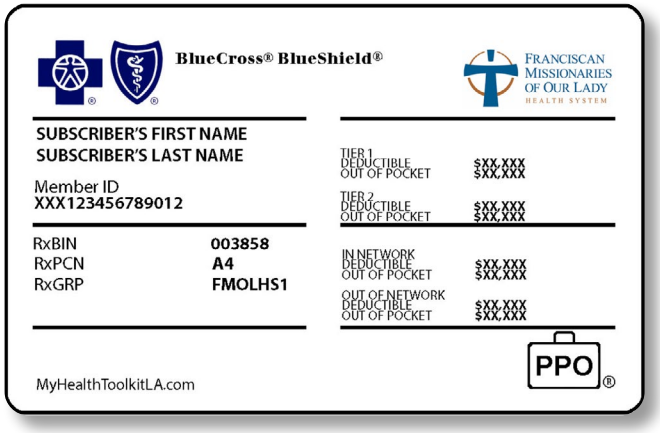
You can access your digital card through the My Health Toolkit app.

Log in to **My Health Toolkit**

- From your mobile device, select Insurance Card
- From a computer, select Insurance Card and then View Your Card

Important Note:

When you enroll in any FMOLHS Medical Plan, your card should feature "PPO" in the suitcase icon that appears on the front side of the ID card. All the providers included in the FMOLHS Health Plan Networks are contracted with BCBS PPO Product and as such the BCBS Association requires the "PPO" suitcase be present on the card.



Medical Plan Options

As you prepare to enroll in benefits, take a moment to review our three medical plan options to make sure the plan you choose is the right fit for you and your family.

All plans are administered through BCBS. The FMOLHS benefits program includes the EPO Plan, PPO Plan and HDHSA Plan. The plan you select should be chosen based on your family's healthcare needs and your budget, and it's important to remember that your costs – including the premium, annual deductible, coinsurance and out-of-pocket maximum – vary based on the plan you choose. As you consider your options, take a moment to compare them. Here's a quick overview:

If you are enrolling as a newly eligible team member, compare the plans before making your elections.

	EPO Plan	PPO Plan	HDHSA Plan
Network	• Offers access to a narrow network of providers who are in our health system or considered our preferred providers • There is no out-of-network coverage unless otherwise required by law	• BCBS network of providers who have agreed to discount their fees for services* • You may choose out-of-network providers; however, you'll receive a higher level of benefit with a lower out-of-pocket cost when using in-network providers	• BCBS network of providers who have agreed to discount their fees for services • You may choose out-of-network providers; however, you'll receive a higher level of benefit with a lower out-of-pocket cost when using in-network providers
Prescription drug coverage	Express Scripts	Express Scripts	Express Scripts
In-network preventive care covered at 100%	Yes	Yes	Yes
Health Savings Account (HSA)	N/A	N/A	Yes
Costs	Lower per paycheck, lower out-of-pocket costs	Higher per paycheck, lower out-of-pocket costs	Lower per paycheck, higher out-of-pocket costs
Annual deductible (in-network)	$300/Employee Only $600/Employee + Dependents	Varies based on coverage tier	Varies based on coverage tier
Annual out-of-pocket maximum (in-network)	$2,500/Employee Only $5,000/Employee + Dependents	Varies based on coverage tier	Varies based on coverage tier

**If you select the PPO Plan and you reside outside of Louisiana or Mississippi, you are eligible for out-of-area coverage at the Tier 2 coverage level if you see a BCBS provider in your home state. The out-of-area coverage is based solely upon the employed team member's address outside of Louisiana or Mississippi.*

Medical Plan Comparison

The charts on pages 11-18 are summaries of the 2024 Health Plans for FMOLHS. A more comprehensive Schedule of Benefits for the Medical Plans can be viewed for the **EPO Plan**, **PPO Plan** and **HDHSA Plan**. All covered services are subject to medical necessity as determined by the Plan. All out of network services are subject to reasonable and customary (R&C) limitations.

EPO Plan

The EPO Plan will pay the designated percentage of covered charges if the provider is in the EPO network until out of pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year unless stated otherwise. The following charges do not apply toward the out of pocket maximum and are never paid at 100%: deductible(s), cost containment penalties, and above usual and customary charges. There is **no** out-of-network coverage unless otherwise required by law.

	FMOLHS EPO Network	Out-of-Network
Annual Deductible		
Employee Only	$300	No Coverage
Employee & Dependents	$600	No Coverage
Maximum Out-Of-Pocket (includes deductible)		
Employee Only	$2,500	No Coverage
Employee & Dependents	$5,000	No Coverage
Coinsurance		
Employee Cost Share	10%	No Coverage
Preventive Care & Condition Management		
Routine Adult Care Visits & Immunizations	100% coverage limited to one routine physical examination annually and approved wellness screenings annually	No Coverage
Routine Child Care Visits & Immunizations	100% coverage	No Coverage
Smoking Cessation Aids	100% coverage of screening for tobacco use and two tobacco cessation attempts per year, which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90-day supply of Smoking Cessation Aids when prescribed by a healthcare provider without prior authorization	No Coverage
Office Visits		
Primary Care Physician (PCP)	$0 Copay	No Coverage
Specialist	$35 Copay	No Coverage

EPO Plan continued

	FMOLHS EPO Network	Out-of-Network
Emergent/Urgent Care		
Urgent Care	$60 copay	No Coverage
Emergency Room	$250 copay	$250 copay*
Ambulance Service	90% coverage after deductible	90% coverage after deductible*
Facility Services		
Outpatient Surgery	$250 copay	No Coverage
Inpatient Care	$200 copay per day (4 day/$800 max)	No Coverage
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage
Organ Transplant	90% coverage after deductible when performed at Blue Distinction Center facility	No Coverage
Maternity Care		
Prenatal Care	One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy	No Coverage
Labor & Delivery	$200 copay per day (4 day/$800 max)	No Coverage
Breast Pump/Lactation Counseling	100% coverage	No Coverage
Mental Health And Substance Abuse		
Office Visit	$0 Copay	No Coverage
Outpatient	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Inpatient	$200 copay per day (4 day/$800 max)	No Coverage
Other Services		
Allergy Testing/Serums & Injections	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Laboratory & Diagnostic Services	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Occupational, Physical & Speech Therapy	90% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined Occupational, Physical, and Speech Therapy	No Coverage
Applied Behavior Analysis (ABA)	90% coverage after deductible maximum of 20 hours per week annually	No Coverage
Durable Medical Equipment (DME)	90% coverage after deductible	No Coverage

*Per ***No Surprises Act*** in Legal Notices

PPO Plan

The PPO Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: deductible(s), cost containment penalties, and above usual and customary charges.

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Annual Deductible				
Employee Only	$800	$1,200	$3,000	$5,000
Employee & Dependents	$1,600	$2,400	$6,000	$10,000
Maximum Out-Of-Pocket (includes deductible)				
Employee Only	$3,000	$4,500	$6,000	$10,000
Employee & Dependents	$6,000	$9,000	$12,000	$20,000

Out-of-Area Coverage. A subscriber (team member) who is enrolled in the PPO Plan and whose home address is in a state other than Louisiana or Mississippi may (i) access care at Tier 2 network coverage with a BCBS PPO network provider in their home state for themselves and their enrolled dependents or (ii) access providers in the FMOLHS Louisiana and Mississippi networks at Tier 1 or Tier 2 coverage. Any other network access would follow the Tier 3 or Out-of-Network coverage. The Out of Area Coverage is based solely on the subscriber's (team member's) home address. A dependent's address does not entitle the dependent to Out of Area Coverage.

Coinsurance				
Employee Cost Share	20%	30%	40%	60%
Preventive Care & Condition Management				
Routine Adult Care Visits & Immunizations	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	40% coverage after deductible Limited to one routine physical examination annually and approved wellness screenings annually
Routine Child Care Visits & Immunizations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Smoking Cessation Aids	100% coverage of screening for tobacco use and two tobacco cessation attempts per year, which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90-day supply of Smoking Cessation Aids when prescribed by a healthcare provider without prior authorization			No Coverage

PPO Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Office Visits				
Primary Care Physician (PCP)	$5 copay office visit only, all other services subject to deductible and coinsurance	$30 copay office visit only, all other services subject to deductible and coinsurance	60% coverage after deductible	40% coverage after deductible
Specialist	$45 copay office visit only, all other services subject to deductible and coinsurance	$70 copay office visit only, all other services subject to deductible and coinsurance		
Emergent/Urgent Care				
Urgent Care	$75 copay	$75 copay	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible*			
Ambulance Service	80% coverage after deductible*			
Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage	No Coverage	No Coverage
Organ Transplant	80% coverage after deductible when performed at Blue Distinction Center facility			No Coverage
Maternity Care				
Prenatal Care	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy			40% coverage after deductible
Labor & Delivery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Breast Pump/Lactation Counseling	100% coverage	100% coverage	100% coverage	No Coverage

*Per ***No Surprises Act*** in Legal Notices*

PPO Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Mental Health And Substance Abuse				
Office Visit	$5 copay	$30 copay	60% coverage after deductible	40% coverage after deductible
Outpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums & Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Laboratory & Diagnostic Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational, Physical & Speech Therapy	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage
	Maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy			
Applied Behavior Analysis (ABA)	80% coverage after deductible; max 20 hours per week annually	70% coverage after deductible; max 20 hours per week annually	60% coverage after deductible; max 20 hours per week annually	No Coverage
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage

HDHSA Plan

The HDHSA Plan is a high deductible health plan with a tax-free **health savings account (HSA)**. You determine how much you'll contribute to the account, when to use the money to pay for qualified medical, prescription, dental and vision services, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. Company HSA contributions will be pro-rated based on enrollment date.

You cannot open an HSA if:

- You have other health coverage that helps you pay for healthcare expenses before your deductible is met.
- You or your spouse has a flexible spending account (FSA) or health reimbursement arrangement (HRA). (You are allowed to participate in a Limited Use FSA, which would only cover Dental and Vision expenses.)
- You also have Medicare or TRICARE.
- Someone else claims you as a dependent.
- You have used Veterans Affairs hospital or medical services in the three months prior to opening your HSA, unless it was for a disability related to your military service.

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
HSA Annual Contributions				
Employee Only	$750			
Employee & Dependents	$1,500			
Annual Deductible (Aggregated)				
Employee Only	$1,750	$2,500	$3,500	$5,000
Employee & Dependents	$3,500	$5,000	$7,000	$10,000
Maximum Out-Of-Pocket (Includes Deductible) (Embedded OOP)				
Employee Only	$3,500	$5,000	$7,000	$10,000
Employee & Dependents	$7,000	$10,000	$14,000	$20,000

The Out-of-Area coverage is not available under the High Deductible HSA Plan.

Coinsurance				
Employee Cost Share	20%	30%	40%	60%

HDHSA Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Preventive Care & Condition Management				
Routine Adult Care Visits & Immunizations	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	40% coverage after deductible Limited to one routine physical examination annually and approved wellness screenings annually
Routine Child Care Visits & Immunizations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Smoking Cessation Aids	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90-day supply of Smoking Cessation Aids when prescribed by a healthcare provider without prior authorization			No Coverage
Office Visits				
Primary Care Physician (PCP)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Specialist	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Emergent/Urgent Care				
Urgent Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible*			
Ambulance Service	80% coverage after deductible*			
Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage	No Coverage	No Coverage
Organ Transplant	80% coverage after deductible when performed at Blue Distinction Center facility			No Coverage

*Per ***No Surprises Act*** in Legal Notices

HDHSA Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Maternity Care				
Prenatal Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Labor & Delivery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Breast Pump/Lactation Counseling	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Mental Health And Substance Abuse				
Office Visit	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Outpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums & Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Laboratory & Diagnostic Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational, Physical & Speech Therapy	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage
	Maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy			
Applied Behavior Analysis (ABA)	80% coverage after deductible; max 20 hours per week annually	70% coverage after deductible; max 20 hours per week annually	60% coverage after deductible; max 20 hours per week annually	No Coverage
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

Note:

When you enroll in the HSA plan, Voya will provide you with a debit card that includes the FMOLHS employer contribution to help pay for eligible expenses.

Easy Steps to Navigate Our Network

In-Network

We understand the importance of finding a healthcare provider who can best meet the needs of you and your family. We also understand how daunting it might be to scroll through a list of doctors in search of the best fit. Our **Network Guides** can help you:

- Find a provider in network
- Check if a provider you are already seeing is in network prior to enrollment
- Assist with scheduling an appointment with network-based primary care physicians
- Check availability of a specialty service within our network

Call **(855) 875-6265** to connect with a Network Guide today.

Note:

Always verify a provider's network status by calling Blue Cross Blue Shield at (833) 468-3594 or by logging on to MyHealthToolkitLA.com/links/FMOLHS. If the provider address listed on the directory is not the address where care will be delivered, the provider may not be in network. Contact BCBS to confirm.

Did you know?

The FMOLHS customized network (EPO and PPO Tier 1 and 2) is designed to drive care to providers employed by the health system or who are partners of the health system. By using providers and facilities in the FMOLHS customized network, we are helping to preserve the future of our organization and our mission. The EPO network includes the same providers in the PPO Tier 1 and Tier 2 networks.

Healthcare

Navigating Care & Costs

No Cost and Lower Cost Care

MyChart

No Cost to You

Message your provider for advice or nonemergent questions about your health or medications through your MyChart portal.

- New onset health questions
- Treatment options
- Prescription drug questions or refill requests
- Advice for a health problem
- Schedule in-person or video visit appointments

No appointment needed. If further help is recommended your provider will suggest an appointment.

Video Visits

Fast, easy way to see your provider on your smartphone, tablet, or computer.

- Allergies
- Sinus Infections
- Cold and Flu
- Fevers
- Insect Bites
- Pink Eye
- Rashes
- UTI
- Headaches
- Medication management

Convenient appointments offered through 8 p.m. Meet with an FMOLHS primary care provider in our network for free with the EPO Plan or $5 with the PPO plan. (Visits can be scheduled through MyChart.)

Primary Care Provider (PCP)

See your provider in-person for an illness or new medical issue and for care coordination with specialty providers. Same day visits are available.

- Screenings, checkups, vaccines
- Recent hospital stay follow ups
- Medication questions or refills
- Talk about medical concerns
- Chronic Diseases (Diabetes; COPD; High Blood Pressure; Asthma)
- Depression or Anxiety
- Pain
- Muscle Pain
- Sprains
- Low Back Pain
- Migraines, headaches with stiffness in neck
- Minor cuts, minor burns, eye injuries
- Infections
- Flu, Colds, Strep
- Fever over 24 hours
- Rash
- Urinary Tract Infections
- Cough, congestion, sinus problems
- Ear infections

Appointments offered during normal business hours and extended hours depending on location. (Visits can be scheduled through MyChart.)

Healthcare

Navigating Care & Costs

Higher Cost Care

Walk-In or Urgent Care

When you are unable to see your primary care provider the same day. For non-life-threatening medical issues that need urgent attention.

*It's important to communicate with your primary care provider after your urgent care visit to provide an update on any new medical issues or medication changes.

No appointment needed. If further help is recommended, your provider will suggest an appointment.

Emergency Room

Emergency same day care for serious or life-threatening illnesses and injuries. Call 911 immediately for critical needs.

- Serious head, neck, or body injuries
- Stroke symptoms, facial drooping, trouble speaking, vision loss, numbness arms/legs (Call 911)
- Chest pain, pressure, numbness arms/legs (Call 911)
- Severe cuts, bleeding, pain, burns
- Severe broken bones, especially bones through skin
- Severe allergic reactions
- Seizures
- Falls, weakness
- Poisoning
- Other life-threatening conditions

No appointment needed due to critical medical need.

Care Outside Our Network

Although this is not common, there may be times when an in-network provider is not available within the FMOLHS customized network (EPO and PPO Tier 1 and Tier 2). In such a situation, a network exception may be available. To receive an exception, you must complete the Network Exception form and have it signed by your provider. Signed and completed forms must be submitted to BCBS of South Carolina **before services are rendered to be considered**. BCBS SC will notify you of their decision on your request.

Submit all completed requests in writing via:

- Fax: **(803) 264-0259**
- By email: **fmolhsexception@bcbssc.com**
- By mail:

  Blue Cross Blue Shield of South Carolina
  Attn: Network Waiver, AX-630
  P.O. Box 100300
  Columbia, SC 29202

Note:

The network exception MUST be requested and approved before services are rendered. If the request is made after services are rendered, it will not be considered unless otherwise required by law.

Preauthorization Requirement List

Before our medical plans provide benefits for certain services and supplies, preauthorization may be required. To preauthorize services, your provider can contact BCBS at **(833) 468-3594**. If preauthorization requirements are not met, covered expenses will be paid at 50% if the services are medically necessary and 0% if the services are not medically necessary. If you have any questions regarding medical preauthorization, call BCBS at **(833) 468-3594**.

The following services, supplies and care must be preauthorized, or reimbursement from the Plan may be reduced.

- All Inpatient Admissions (Includes acute, Skilled, Rehabilitation, LTAC, Residential, and Treatment Room Services)
- All Clinical Trials, Experimental & Investigational Procedures/ Treatment
- All Transplant Services Including Pre-Transplant Evaluations
- All Out-of-Network and Out-of-Area Services, Procedures, Surgeries
- All Plastic & Reconstructive Surgeries & Procedures (Cosmetic procedures are excluded from coverage)
- All CT Scans. MRIs, and PET scans including CTAs and MRAs
- 17 Alpha-Hydroxyprogesterone Caproate (17P)
- Alcohol/Substance Abuse
- Bariatric Surgery, including revisional surgery
- Durable Medical Equipment (purchases over $500 and all rentals)
- Enteral Feedings
- Genetic Studies/Testing/ Therapy
- Home Health
- Hyperbaric Oxygen Therapy
- Specialty Medications including Injectables and IV Infusions
- Mental Health Services (Inpatient, Outpatient, and Residential Services only)
- Orthotics and Prosthetics over $500
- Pain Management procedures including Epidural Steroid Injections
- Podiatry treatment/Foot Care
- Diagnostic studies and/ or treatment of Sleep Disorders
- Surgery (hysterectomy, varicose vein, nasal/septal surgery, breast reduction, surgical intervention to correct sleep apnea, oral surgery)
- Therapies – Physical, Speech, Occupational and ABA
- Non-Emergent Air Ambulance and Non-Emergent Ambulance Transportation
- Weight Loss Medications (Authorized by Healthy Lives)

This list is not inclusive of all codes requiring preauthorization; please contact Member Services for benefits, eligibility, and code specific requirements at (833) 468-3594.

Note: Preauthorization of services is not a guarantee of payment of services.

Pharmacy Benefits

Each of our medical plan options includes prescription drug coverage through Express Scripts.

All prescription drugs covered by the plan are categorized into four tiers: Generic, Preferred, Non-Preferred and Specialty Drugs. Your cost is based on the tier assigned to the prescription drug and whether the medication is for a 30-day or 90-day supply. You may contact Express Scripts for information on your benefit coverage and search for network pharmacies by logging on to **express-scripts.com/fmolhs** or calling Express Scripts Customer Care at **(877) 816-8717**.

Tips to Make the Most of Your Prescription Drug Coverage

The cost of prescription drugs is rising faster than many other healthcare services and supplies. Here are a few ways to help you save:

- Use mail order service for maintenance medications. If you regularly take medication to treat a chronic condition, such as an allergy, heart disease, high blood pressure, or diabetes, use the RxONE mail order option for a 90-day supply for a lower copay.
- Ask your doctor about generic medications. Generic medications are generally just as effective as brand-name medications, yet the cost of generics is substantially lower for you and FMOLHS.
- Review your plan to understand the benefits provided for prescription drugs. Visit **express-scripts.com/fmolhs** to check your plan's coverage and find prices of medications covered.

Reduce Your Out-of-pocket Costs for Medications through RxONE

RxONE is our FMOLHS-owned, in-house pharmacy, where you can receive reduced copays for prescriptions, including mail order/90-day prescriptions and specialty medications. In addition to discounts, RxONE offers personal service through their in-store or curbside delivery options, faster fill times, immunizations and ease of access to our pharmacists. Find an RxONE pharmacy location near you to begin taking advantage of the cost savings and personalized service.

Healthcare

The tables on the following pages show the prescription drug benefits (retail and mail order pharmacies) provided through the FMOLHS medical plans.

EPO Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	$10 copay	$15 copay
Generic diabetic prescription medications and supplies	$0 copay	$0 copay
Preferred drug	$35 copay	$70 copay
Non-preferred drug	$70 copay	$110 copay
Specialty drug	Filled by RxONE – $100 copay	Filled by Express Scripts – $150 copay
Mail order pharmacy (90-day supply – RxONE or Express Scripts)		
Generic drug Preferred drug Non-preferred drug	2x in-house copay*	3x network copay*
Brand-name drugs when generic is available		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.	
Immunizations		
	According to CDC immunization schedules; subject to age limitations	

**Mail order copays do not apply to mail order specialty prescriptions*

PPO Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	$10 copay	$15 copay
Generic diabetic prescription medications and supplies	$0 copay	$0 copay
Preferred drug	$45 copay	$70 copay
Non-preferred drug	$70 copay	$110 copay
Specialty drug	Filled by RxONE – $100 copay	Filled by Express Scripts – $150 copay
Mail order pharmacy (90-day supply – RxONE or Express Scripts)		
Generic drug Preferred drug Non-preferred drug	2x in-house copay*	3x network copay*
Brand-name drugs when generic is available		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.	
Immunizations		
	According to CDC immunization schedules; subject to age limitations	

**Mail order copays do not apply to mail order specialty prescriptions*

HDHSA Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	20% after deductible	20% after deductible
Generic diabetic prescription medications and supplies	20% after deductible	20% after deductible
Preferred drug	20% after deductible	20% after deductible
Non-preferred drug	20% after deductible	20% after deductible
Specialty drug	20% after deductible	20% after deductible
Mail order pharmacy (90-day supply – RxONE or Express Scripts)		
Generic drug Preferred drug Non-preferred drug	20% after deductible	
Brand-name drugs when generic is available		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.	
Immunizations		
	According to CDC immunization schedules; subject to age limitations	

**Mail order copays do not apply to mail order specialty prescriptions*

Just Premium

Through the "Just Premium" program, team members who apply and qualify for financial assistance based on total household income can receive a reduced premium for the EPO and PPO plan options.

The program aligns with our Mission and provides eligible full-time equivalent team members with higher FMOLHS subsidies to improve affordability and access to healthcare coverage.

Based upon your total household income (adjusted gross income), the number of dependents you claim on your 2022 Federal Individual Income Tax Return, and your hourly base rate, you and your family may be eligible for the Just Premium reduction.

Dependents Listed on Tax Return	Maximum Household Income
0	$25,515
1	$34,510
2	$43,505
3	$52,500
4+	$61,495
Current maximum hourly rate: $32.00	

To apply for Just Premium:

1. Select My Benefits on our Total Rewards site and then click on the **2024 Just Premium Application** link.
2. Print and complete the application and attach a copy of the first two pages of your 2022 Federal Individual Income Tax Return. If you are married, filing jointly, submit one tax return. If you are married, filing single or head of household, you'll need to submit copies of the first two pages of your tax return and your spouse's return.
3. Return the application and tax return(s) to **JustPremium@fmolhs.org** or fax **(225) 765-9307** within 30 calendar days of your new hire/new eligibility date.

Note:

If you did not file a 2022 Income Tax Return, you will not be eligible for the 2024 Just Premium program.

2024 Medical Plan Premiums

Bi-weekly team member contributions (26 contributions annually)

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
EPO Plan				
Just Premium	$23.87	$103.98	$47.16	$129.55
Standard premium	$55.07	$177.85	$109.19	$233.97
Part-time premium	$55.11	$299.46	$200.96	$388.26
PPO Plan				
Just Premium	$59.18	$222.52	$112.69	$281.62
Standard premium	$123.35	$317.85	$224.02	$415.59
Part-time premium	$179.76	$450.90	$336.75	$603.61
HDHSA Plan				
Just Premium	N/A	N/A	N/A	N/A
Standard premium	$94.15	$255.75	$219.31	$353.66
Part-time premium	$137.22	$362.81	$329.68	$465.60

For more information about Just Premium, see **page 27**.

Dental Plan Options

Proper dental care plays an important role in your overall health. FMOLHS offers two dental plans through Delta Dental: the Basic Plan and the Buy Up Plan.

Both options provide preventive care at 100% and benefits for a variety of other dental care services. The plans allow you to visit any licensed dentist, but you'll maximize the value of the plan when you receive dental services from **Delta Dental's network** of providers.

	Basic Plan	Buy Up Plan
Annual Deductible		
Employee and each covered family member	$50 per person, up to $150 per family	$50 per person, up to $150 per family
Calendar Year Maximum (For Covered Services)		
Employee and each covered family member	$1,000 per person	$1,550 per person
Class I: Preventive and Diagnostic Services	Covered at*	Covered at*
Oral exams and cleanings: (2x per calendar year) X-rays: Full mouth (1 every 36 months) Bitewing (1 series per 12 months) Fluoride application: (Limited to children under 16 years old) (1 per calendar year) Space maintainers: (Limited to non-orthodontic treatment)	100%, no deductible	100%, no deductible
Class II: Basic Restorative Services		
Fillings, endodontics, periodontal scaling, denture adjustments and repairs, extractions, anesthetics, oral surgery including boney impacted wisdom teeth	50%**	80%**
Class III: Major Restorative Services		
Crowns, dentures, bridges	50%**	50%**
Class IV: Orthodontia	No coverage	50%**
Lifetime maximum (for orthodontia services only) applies to dependent children under 19 years old		$1,500

** Up to a maximum allowed charge (excludes exams, cleanings and X-rays)*
*** After plan deductible.*

Healthcare

Dental Plan Premiums

Dental premium contributions are deducted semi-monthly from your paycheck on a before-tax basis (24 deductions annually).

	Basic Plan	Buy Up Plan
Full Time		
Employee Only	$4.24	$8.39
Employee & Family	$25.51	$37.54
Part Time		
Employee Only	$8.14	$14.89
Employee & Family	$29.41	$44.04

Questions about your dental benefits?

Contact Delta Dental at **(800) 521-2651**.

You are responsible for paying costs that exceed the allowance provided for lenses, frames and contact lenses.

Vision Plan Options

Our benefits program includes two options for vision care through EyeMed Vision Care: the Basic Plan and the Buy Up Plan. Vision care includes regular eye exams, which can help detect diseases like glaucoma, diabetes and loss of sight. Hearing aid discounts are available through both plan options. **Providers in the EyeMed Vision Care network offer the lowest out-of-pocket costs, and your copayments will be paid directly to the provider.** To find a network provider, log on to **EyeMed's website**. If you choose an out-of-network provider, your copayment will be deducted from the out-of-network reimbursement.

	Basic Plan			Buy Up Plan		
	PLUS Network Providers	Insight Network Providers	Non-Network Providers	PLUS Network Providers	Insight Network Providers	Non-Network Providers
Copay						
Examination	No charge	$10 copay	Up to $40 allowance	No charge	$10 copay	Up to $40 allowance
Materials	$15 copay	$15 copay	See below	$10 copay	$10 copay	See below
Benefit Frequency						
Examination	One every plan year			One every plan year		
Lenses	One every plan year			One every plan year		
Frames	One every plan year			One every plan year		
Contacts (in lieu of Lenses and Frames)	One every plan year			One every plan year		
Covered Materials						
Standard Plastic Lenses*						
Single vision lenses	$15 copay		Up to $30 allowance	$10 copay		Up to $30 allowance
Bifocal lenses	$15 copay		Up to $50 allowance	$10 copay		Up to $50 allowance
Trifocal lenses	$15 copay		Up to $70 allowance	$10 copay		Up to $70 allowance
Lenticular	$15 copay		Up to $70 allowance	$10 copay		Up to $70 allowance
Progressive - standard	$70 copay		Up to $50 allowance	$65 copay		Up to $50 allowance
Progressive - premium	$100-190 copay		Up to $50 allowance	$95-$185 copay		Up to $50 allowance
Frames						
Retail frame equivalent	$150 allowance	$100 allowance	Up to $50 allowance	$200 allowance	$150 allowance	Up to $75 allowance
Contact Lenses						
Elective	$100 allowance		Up to $50 allowance	$150 allowance		Up to $75 allowance
Medically necessary	No charge		Up to $300 allowance	No charge		Up to $300 allowance

**Contact lenses are in lieu of eyeglass lenses and frames benefit.*

Vision Plan Premiums

Vision premium contributions are deducted semi-monthly from your paycheck on a before-tax basis (24 deductions annually).

	Basic Plan	Buy Up Plan
2024 Premiums		
Employee	$1.89	$2.92
Employee + Spouse	$3.59	$5.84
Employee + Child(ren)	$3.78	$7.31
Family	$5.56	$8.05

Questions about your vision benefits?

Contact EyeMed at **(866) 804-0982.**

Health Savings & Spending Accounts

Health Savings Account (HSA)

Take charge of your healthcare spending with a Health Savings Account (HSA). Your HSA can be used for qualified expenses, including doctor's office visits, eye exams, prescription expenses, laser eye surgery and more. You'll find a complete list of eligible expenses at **IRS.gov**.

The HSA has triple tax advantages:

1. No federal income taxes are required on the money you or FMOLHS contribute to the account. In most states, you avoid state taxes on the account, too.
2. The earnings on your HSA grow tax-free. The account is a great way to save money for healthcare expenses throughout your career and during retirement.
3. The money you withdraw to pay for eligible medical expenses – today or in the future – is not subject to taxes.

Note that HSA elections do not automatically continue from year to year. You must actively enroll each year.

Here's How the HSA Works.

1. **Select the HDHSA Medical Plan for 2024.**
2. **Select your contribution.**

	FMOLHS will contribute up to	You can contribute up to
Employee only	$750	$3,400
Family	$1,500	$6,800

If you are 55 or older, you may contribute an additional $1,000 each year in catch-up contributions.

3. **FMOLHS will establish an HSA account with Voya Financial in your name** and send in your contribution once bank account information has been provided and verified. The FMOLHS contribution will be made at one time, while your contribution will be spread over 26 pay periods or the remaining pay periods based on your new eligibility date and effective date of coverage.
4. **Use your debit card** issued by Voya or submit eligible expenses for payment or reimbursement. If you contribute to both the HSA and LUFSA, one debit card issued by Voya will access both accounts.
5. **Grow your account! Unused balances roll over from year to year.** The account can add up to a substantial nest egg during your career.
6. **All of the money in the account is yours** to use for eligible healthcare expenses now or in the future – even if you retire or leave FMOLHS.

Health Savings & Spending Accounts

Health Savings Account (HSA)

Important Note:

You are eligible to open and contribute to an HSA if:

- You are enrolled in the HDHSA plan.
- You are not covered by your spouse's medical or FSA plan.
- Your spouse does not have a Medical FSA or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

For more HSA information, visit Voya's website.
If you do not complete the vetting process and open your HSA with Voya, contributions will be returned and may be taxable to you.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes.

When you participate in an FSA, your contributions are deducted from your pay on a pre-tax basis and deposited into your FSA. All of the money you elect for the plan year is available on day one and you can use the account to pay for **eligible expenses**. When you enroll in an FSA, you'll receive a debit card that can be used for eligible expenses. You may also pay an invoice and then request reimbursement from your account.

Questions about the FSAs?

We've got answers!

Here's a quick overview of your FSA options:

Account Type	Who's Eligible	Eligible Expenses	Contribution Limits	"Use it or Lose it" at the end of the year?	Benefit
Medical Flexible Spending Account	Benefits-eligible team members	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, deductibles, eyeglasses and prescribed over-the-counter medications)	$3,050	Yes	Save on eligible expenses not covered by insurance; reduces your taxable income
Limited Use Flexible Spending Account (LUFSA)	Benefits-eligible team members enrolled in the HDHSA Medical Plan or another high deductible health plan with an accompanying HSA	Most dental and vision care expenses that are not covered by the medical plan*	$3,050	Yes	Save on eligible expenses not covered by insurance; reduces your taxable income

**When you use your Voya debit card to pay for eligible dental and vision expenses, the available dollars will always pull from LUFSA first until that account is exhausted and then the dollars will pull from your HSA.*

General FSA Rules and Restrictions

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for healthcare FSAs:

- Your expenses must be incurred during the 2024 plan year.
- Your dollars cannot be transferred from one FSA to another.
- You must "use it or lose it"– any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you have a qualified life status change, such as a marriage, divorce or birth of a child.

Note that FSA elections do not automatically continue from year to year. You must actively enroll each year.

Life and AD&D

Income Protection

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

Basic Life and Accidental Death & Dismemberment (AD&D) insurance coverage is an important component of your financial security. Benefits-eligible team members are automatically enrolled in this coverage through Lincoln Financial Group. Your Basic Life and AD&D coverage is equal to 1.5 times your basic annual earnings (up to a maximum of $50,000). **FMOLHS pays the full cost of this benefit.**

Update Beneficiary Information

It's important to name a primary and contingent beneficiary – and to keep their information up to date – for your life and AD&D insurance coverage. Log into **Oracle Employee Self Service** to designate a beneficiary or update beneficiary information for your Basic Life and AD&D coverage and voluntary life insurance coverages. When making your elections in **Oracle Employee Self Service**, you will be prompted to designate a beneficiary under the Life Insurance Plans. If you need to make a change to your beneficiary after your initial enrollment, you can do so any time during the year.

Life and AD&D

Group Life Insurance

	Basic Life
Coverage Amount	1.5x annual salary
Who Pays	Company pays full cost
When Benefits Are Payable	If you die while covered under the plan
Maximum Benefit	$50,000
When Can I Change My Election	N/A

Benefit Reductions

Benefits through Basic Life and AD&D Insurance will be reduced when you reach certain ages, as shown in the chart on the right.

If you are age 65 or older upon enrollment in Employee Life and AD&D Insurance, the age reductions shown in the chart will apply to any guaranteed issue amount and to the maximum eligible amount.

Age	Reduction
At age 65	Benefit will reduce by 35% of the original amount
At age 70	Benefit will reduce an additional 15% of the original amount
At age 75	Benefit will reduce an additional 15% of the original amount
At retirement	Benefit will terminate when the insured person retires

Life and AD&D

Voluntary Term Life Insurance

In addition to the Basic Life and AD&D insurance provided by FMOLHS, you may elect voluntary term life insurance coverage offered by Lincoln Financial Group. You may choose coverage for yourself, your spouse and/or your dependent child(ren).

	Voluntary Employee Life	Voluntary Spouse Life	Voluntary Dependent Life
When You Can Enroll	Team members who are within their first 30 days of eligibility may enroll through **Oracle Employee Self-Service**. New team members may enroll in $10,000 increments up to a maximum of $150,000. If you terminate coverage, you will not have an opportunity to re-enroll.	Team members who are within their first 30 days of eligibility may enroll through **Oracle Employee Self-Service**. You must be enrolled in Voluntary Employee Life in order to elect Spouse coverage. Spouse coverage amount cannot exceed the team member's elected coverage amount. If you terminate coverage, you will not have an opportunity to re-enroll.	Team members who are within their first 30 days of eligibility may enroll through **Oracle Employee Self-Service**. You must be enrolled in Voluntary Employee Life in order to elect Dependent coverage. If you terminate coverage, you will not have an opportunity to re-enroll.
Coverage Amount	$10,000 increments	$10,000 increments	$10,000
Maximum Benefit	$150,000 initial enrollment	$30,000	$10,000

Coverage is portable – you can take your coverage with you if you leave FMOLHS. To port your coverage, contact Lincoln Financial Group within 31 days of your coverage terminating and pay the applicable premium. See your certificate for details.

Note:

If you are not actively at work, the effective date of your coverage will be delayed. In addition, your spouse and dependents cannot be in a period of limited activity on the day coverage takes effect. Dependent child(ren) are eligible from age 14 days to age 26, regardless of marital or student status.

Disability Program

FMOLHS provides Short Term Disability (STD) and Long Term Disability (LTD) administered by Lincoln Financial.

Short Term Disability (STD)

FMOLHS provides Short Term Disability (STD) insurance at no cost to part-time and full-time benefits-eligible team members (0.50-1.0 FTE). This coverage provides protection for up to 60% of your basic annual earnings if you become partially or totally disabled for a short period of time. The STD benefit is payable following seven (7) days of a qualifying illness or injury. The benefit is payable for up to 12 weeks.

Long Term Disability (LTD)

Our benefits program includes Long Term Disability (LTD) insurance to full-time benefits-eligible (0.8-1.0 FTE) team members. FMOLHS provides Group Core LTD which offers coverage that protects up to 50% of your basic monthly salary if you become partially or totally disabled for a long period of time. You and FMOLHS share the cost of this coverage.

You may elect optional coverage through the Group Buy Up LTD plan which provides a benefit of up to 60% of your basic monthly salary. You pay the full cost of the Group Buy Up LTD coverage.

	Group Core LTD	Group Buy-Up LTD
Coverage Amount	50% of basic monthly salary	60% of basic monthly salary
Who Pays	You & FMOLHS share cost	You pay full cost
When Benefits Are Payable	Following 90 days of disability	Following 90 days of disability
Maximum Monthly Benefit	$3,000 per month	$10,000 per month
When Evidence of Insurability is Required	Any election after original enrollment period	Any election after original enrollment period

Payments continue as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Any other benefits you receive (such as Social Security, Workers' Compensation, pension benefits, or benefits from any similar act or plan) will reduce your LTD benefit amount. Certain exclusions, as well as pre-existing condition limitations, may apply.

See page 46 for information about the FMOLHS Leave of Absence Program.

Other Voluntary Benefits

FMOLHS offers voluntary benefits through Lincoln Financial Group to all eligible team members. These benefits are designed to provide financial security at an affordable price. You pay for this coverage through payroll deduction (24 deductions).

Critical Illness Insurance

Critical Illness Insurance through Lincoln Financial Group can provide financial support to help you through a serious illness, such as a heart attack, cancer or stroke. This coverage provides a lump-sum benefit to cover out-of-pocket expenses for your treatment, to pay coinsurance, or to take care of everyday living expenses, which may include housekeeping services, special transportation services and childcare.

Take a moment during your enrollment period to review the **highlights of the Critical Illness Insurance** policy.

Rates for Critical Illness are based on your attained age. This means your rate will change as you age. You can view the current rates in Oracle Employee Self Service when enrolling in coverage.

Hospital Indemnity Insurance

A Hospital Indemnity Insurance plan is available to all team members. This voluntary plan is provided by Lincoln Financial Group and provides supplemental payments associated with a hospital stay that you can use for any purpose, including mortgage/rent payments, utilities, childcare, copayments, coinsurance and deductibles. Hospital Indemnity Insurance can help pay for out-of-pocket costs associated with a hospital stay. It pays both admission and daily benefits for these stays. If you elect this insurance, you'll pay for coverage through payroll deductions.

Review the **highlights of the Hospital Indemnity Insurance** voluntary plan to learn more.

Voluntary Accident Insurance

Voluntary Accident Insurance through Lincoln Financial Group helps protect you from unexpected financial stress if you or a covered family member has an accident. The coverage supplements your primary medical plan by providing cash benefits in cases of covered accidental injuries. You can use this money to help pay for medical expenses not paid by your medical plan (such as your deductible or coinsurance) or for anything else, including everyday living expenses.

Accident insurance pays cash for accidental injuries, covers multiple injuries from the same accident, is available for spouses and children, includes travel assistance and includes on the job accidents.

As you consider your benefit elections, take some time to review the **highlights of the Voluntary Accident Insurance** policy.

Hospital Indemnity

	Semi-Monthly (24 deductions)
Employee	$6.33
Employee + Spouse	$13.73
Employee + Child(ren)	$9.78
Employee + Family	$17.91

Voluntary Accident

	Semi-Monthly (24 deductions)
Employee	$3.96
Employee + Spouse	$5.77
Employee + Child(ren)	$6.97
Employee + Family	$9.24

Time Off

Time Off

Our Total Rewards package includes several time off programs for benefits-eligible team members.

Paid Time Off (PTO)

Eligible team members begin earning PTO immediately upon hire. Time used will be based on the accrual earned. The annual accrual schedule* is:

0 – 4 years	132 hrs (16.5 days)
5 – 9 years	156 hrs (19.5 days)
10 – 14 years	180 hrs (22.5 days)
15 – 19 years	204 hrs (25.5 days)
20 – 24 years	228 hrs (28.5 days)
25 years +	252 hrs (31.5 days)

You may carry over PTO, up to a maximum of 328 hours.

**Part-time PTO accrual rates are prorated (Years of service credit is determined by adjusted hire date.)*

PTO Sell Back

To help team members manage PTO balances, FMOLHS offers a PTO Sell Back program. You may elect to sell back future PTO accruals during the annual Open Enrollment period if eligible. The combination of PTO accruals and PTO sell back accruals must not exceed 328 hours. Hours in excess of 328 will not be paid out to you.

Holidays

FMOLHS recognizes these holidays: New Year's Day, Good Friday, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Part-time holiday accrual rates are prorated.

Bereavement Leave

The program provides up to three (3) scheduled workdays (not to exceed 24 hours) paid leave for a death in your immediate family (parent, step-parent, brother, sister, spouse, dependents including stepchildren, parent-in-law, grandchildren, grandparent and great-grandparent).

Jury Duty

The policy applies to all team members and provides for time off from regularly scheduled work to serve on a local, state or federal jury in response to a jury summons and may be eligible for jury compensation.

Retirement

Our retirement benefits are a cornerstone of our benefit program and demonstrate our support for your financial future.

403(b) Savings Plan

The FMOLHS 403(b) retirement plan features:

- Core contributions from FMOLHS
- Matching contributions from FMOLHS when you contribute to the plan

403(b) Core Contribution

If you work at least 1,000 hours during the year and are employed on the last day of the calendar year, you are eligible for a core contribution of 2% of your pay into your 403(b) account. The payment is made annually, and you do not need to contribute to the 403(b) Savings Plan to receive the FMOLHS core contribution.

Your Contributions

The 403(b) Savings Plan is a convenient way to save for your future through payroll deductions. When you enroll in the plan, you may contribute up to 100% of your pay on a pre-tax or Roth (after-tax) basis, up to the IRS annual limit ($23,000 in 2024). If you are 50 or older (or will reach age 50 by the end of 2024), you may contribute an additional $7,500 annually in catch-up contributions.

Newly hired team members are automatically enrolled in the plan at a 4% contribution rate. You may change your deferral rate or opt out at any time.

FMOLHS Matching Contributions

When you contribute to the 403(b) Savings Plan, you are eligible to receive matching contributions from FMOLHS. You must work at least 1,000 hours during the year and be employed on the last day of the calendar year to be eligible. FMOLHS will provide a 50% matching contribution for each dollar you contribute to the plan, up to the first 6%. For example, if you contribute 6% of your pay to the 403(b) Savings Plan, FMOLHS will add an additional 3% to your account. The matching contributions are made annually.

Vesting

FMOLHS core contributions and matching contributions are 100% vested after three years of service. If you leave FMOLHS before being fully vested, you will forfeit the core and matching contributions. You are always 100% vested in your contributions and their earnings.

Enroll in and manage all of your FMOLHS retirement accounts at LincolnFinancial.com/FMOLHS.

Health and Well-Being

FMOLHS offers an engaging well-being program designed to help all team members grow and thrive by participating in health and well-being activities.

By participating in the 2024 Health and Wellness Program, you'll make progress on your personal well-being goals, earn points toward rewards, and have fun completing the program's various activities and challenges. You can earn up to 550 points or $550 in rewards.* Rewards include Amazon items, hotels, virtual pre-paid cards, e-gift cards, movie tickets, or cash the points in for additional money in your paycheck. Points are available for redemption on the 15th of each month.

**The maximum annual awards are prorated based on your employment status: full-time 100%, part-time 50% and PRN 25%. To receive the reward, you must be actively employed by FMOLHS on the date of the reward payment. Reward payments are subject to state and federal taxes.*

To participate in the 2024 Health and Wellness Program and begin earning points, follow these steps:

1. **Complete your HRA Questionnaire** on the Healthy Lives app or **online**
2. **Schedule and complete your wellness visit** with your PCP between December 16, 2023 and December 15, 2024. During your visit, you'll have a wellness exam and biometric screening.
3. **Participate in approved activities** that help you achieve your goals and earn rewards. View the catalog of **approved activities** and choose activities and challenges that fit your work-life schedule. Follow the steps to confirm your participation in the activities.
4. **Redeem your rewards points!** Visit the **Awardco site** to register and access your rewards.

Our wellness partner, Healthy Lives, offers personal health coaches to help you understand wellness screening results and create a customized well-being plan. You can earn points for working with the personal health coach, too!

Visit the Healthy Lives website or call (855) 426-4325 for more information.

Health and Well-Being

Employee Assistance Program (EAP)

Caring for your mental health is an essential element of overall wellness.

FMOLHS has partnered with New Directions to provide professional and confidential support for personal and family issues. Employee Assistance Program (EAP) services are available to you and your family 24/7 every day of the year to help through day-to-day challenges, major life changes, and anything in between.

NEW DIRECTIONS®

Support line
Call anytime **(800) 624-5544**

Mobile App
Search for New Directions EAP

Web
Visit **ndbh.com** for resources

Company code: FMOLHS

The EAP provides up to **six (6) NO COST** consultations, which may be in-person or via text and video and supported by online behavioral health tools. New Direction counselors will listen to your concerns, help you identify the source of the problem, and work with you to develop a solution as quickly as possible. The EAP offers:

- Counseling
- Consultations on:
  - Finances
  - Legal needs
  - Managing employees
  - Life
- Crisis support
- Coaching
- Adult and childcare resources
- Personal and professional training

New Directions offers professional counseling services through BetterHelp, the world's largest online therapy platform. Their network of licensed therapists provides convenient and confidential counseling anytime, anywhere through a computer, tablet or smartphone. Follow these steps to get started!

betterhelp

Health and Well-Being

Team Member Discounts

Franciscan Missionaries of Our Lady University (FranU) Discounts

FranU offers discounts to help our Health System Heroes get the education that they deserve. Discounts are offered to non-university FMOLHS team members. We offer a 50% team member discount and a 40% discount to dependents of our team members on the following undergraduate programs:

Associate Degree	Bachelor of Science	Bachelor of Arts	Bachelor of Business Administration
Physical Therapist Assistant **Radiological Technology**	**Health Sciences** • Biology track • Health Service Administration track • Psychology track **Medical Laboratory Science** • MLS • MLT-MLS **Nursing** • Pre-Licensure Nursing (BSN) • Online RN-BSN **Respiratory Therapy** **Biology** • Biochemical Analysis & Instrumentation (BAI) track • Pre-Professional Human Medicine track • Accelerated 3+2 Pathway to Physician Assistant Studies	**Theology** **Psychology**	**Business Administration** 1. General Business track 2. Health Administration track 3. Management track

For more information about FranU, call **(225) 526-1631** or email **admissions@franu.edu**.

FranU Mission Statement

The mission of Franciscan Missionaries of Our Lady University is to educate and form Franciscan servant leaders of all faiths. We honor and preserve the legacy of our founders by preparing highly-skilled professionals, integrated thinkers, and faith-filled citizens. Inspired by the Franciscan Missionaries of Our Lady to be a living witness to Jesus Christ and the Gospel message, the University is in communion with the teachings of the Catholic Church.

Health and Well-Being

Access Perks

Access Perks is a discount program available to all FMOLHS team members. The program offers local and national group discounts when you register on the **Access Perks site**. You'll receive emails about discounts through the website or app. FMOLHS sponsors this benefit and there are no premiums or elections required to participate.

Register Today!

Accessing the mobile app and registering for Access Perks is easy.

1. Download the Access Perks app from the Apple Store or Google Play.
2. Open the app and click on "Set Up Account" to register. **(For the registration, your employee ID will be the first two letters of your first name and your Oracle ID (example: AB12345)).**
3. Complete your registration by setting your password.
4. Start saving at thousands of participating providers, including:

The Access Perks mobile app has GPS/Geolocation functionality that allows you to find deals nearby at home or while traveling. Learn more about the program at FMOLHS.AccessPerks.com or call (877) 408-2603.

Leave of Absence Program

In addition to **jury duty and bereavement leave**, our leave of absence program includes the following benefits for eligible team members:

Family & Medical Leave (FMLA): The policy provides up to 12 weeks leave for certain family and medical events. To apply for leave, visit **Lincoln Financial's secure online portal** (enter company code: FMOLHS) or call **(800) 548-0805**. Team members must have at least one year of employment with FMOLHS and have performed at least 1,250 hours of service.

Personal Leave: Team members with at least six months service may be eligible for up to 4 weeks of personal leave, dependent upon manager approval.

Medical Leave: The policy provides for up to 12 weeks of medical leave. The benefit is available to team members upon their date of hire.

Military Leave: Leave while serving in the Uniformed Services, including voluntary and involuntary service and time spent in active duty, inactive duty training and full-time National Guard duty are covered through this policy.

Additional Benefits

To help team members achieve a good balance between their work and personal responsibilities, FMOLHS offers a variety of benefits and programs.

Benefits and Programs to Support You

Education Assistance

FMOLHS offers Education Assistance to help you grow and progress in your professional journey and encourage you to pursue opportunities to further your education.

Eligible part-time and full-time team members can apply to be reimbursed for eligible educational expenses up to the maximum annual allowance of $3,000 for a full-time team member and $1,500 for a part-time team member. View **Education Assistance FAQs** to learn more.

Personal Life Balance

Credit Union: Enroll and elect payroll deductions to save. Signature loans, new and used car loans available.

Employee's Blood Donor Program: Team member and family blood bank program. Participate by giving one unit of blood annually.

Health Center Membership: Discounts on various memberships

Pay Activ: Financial wellness app that provides access to 40% of your earned but unpaid wages before your actual payday.

Worker's Compensation: Medical expenses and wage replacement for on-the-job injuries/exposures as governed by state law.

Work Life Balance

My Recognition Program: Provides recognition for milestones and special occasions including birthday, service anniversary, and Christmas. Points may be rewarded with the recognition and can be redeemed through the **Awardco website**.

Franciscan Service Award: Peer-based recognition of team members who exemplify core values of our organization.

Contacts

FMOLHS Benefit Programs

	Website/Email	Phone
General Benefits Information askHR	askHR@fmolhs.org	(833) 482-7547
Medical Plan Blue Cross Blue Shield	MyHealthToolkitLA.com/links/FMOLHS	(833) 468-3594
Dental Plan Delta Dental	deltadentalins.com	(800) 521-2651
Prescription Drug Coverage Express Scripts	express-scripts.com	(877) 816-8717
Health and Well-Being Program Healthy Lives	healthylives.org	(855) 426-4325
Vision Plan EyeMed Vision	eyemed.com	(866) 804-0982
FSA/HSA Voya	voya.benstrat.com	(833) 232-4673
Basic Life/AD&D Supplemental Life/AD&D Long Term Disability Lincoln National Life Insurance Company	LincolnFinancial.com/FMOLHS	(855) 818-2883
Leave Administration Short Term Disability Lincoln Financial Group	mylincolnportal.com (Enter company code: FMOLHS)	(800) 548-0805
Voluntary Critical Illness, Voluntary Accident Insurance, Voluntary Hospital Indemnity Lincoln Financial Group	LincolnFinancial.com/FMOLHS When contacting LFG, your ID is your full SSN.	(855) 818-2883
Retirement Plans (403(b), 457(b), Pension Plans) Lincoln Financial Group	LincolnFinancial.com/FMOLHS	(877) 562-4738
EAP New Directions	ndbh.com	(800) 624-5544
Financial Wellness App PayActiv	payactiv.com support@payactiv.com	(877) 937-6966
Education Assistance Program askHR	askHR@fmolhs.org	(833) 482-7547

Legal Notices

Required Notices

Important Notice from Franciscan Missionaries of Our Lady Health System About Your Prescription Drug Coverage and Medicare under the FMOLHS Health Plan(s)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Franciscan Missionaries of Our Lady Health System has determined that the prescription drug coverage offered by the FMOLHS Health plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare 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. You may also enroll each year from October 15th through December 7th.

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

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

If you decide to join a Medicare drug plan, your current Franciscan Missionaries of Our Lady Health System coverage 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 herein.

If you do decide to join a Medicare drug plan and drop your current Franciscan Missionaries of Our Lady Health System coverage, be aware that you and your dependents will not be able to get this coverage back.

Legal Notices

Required Notices continued

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Franciscan Missionaries of Our Lady Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed at the end of these notices for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Franciscan Missionaries of Our Lady Health System changes. You also may request a copy of this notice at any time.

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

Date:	January 1, 2024
Name of Entity/Sender:	Franciscan Missionaries of Our Lady Health System
Contact–Position/Office:	Human Resources
Address:	PO Box 83780 Baton Rouge, LA 70884-3780
Phone Number:	(833) 482-7547

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at (833) 482-7547.

Legal Notices

Required Notices continued

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at (833) 482-7547.

HIPAA Special Enrollment Rights

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 towards 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 (i.e. legal separation, 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 coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 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 the 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 towards 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 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at (833) 482-7547.

Legal Notices

Additional Notices

NO SURPRISES ACT NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINTS SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

1. What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

2. You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those Out-of-Network Services, in addition to applicable amounts due for co-payments, coinsurance, deductibles and non-Covered Services.

Specific information about In-Network and Out-of-Network facility-based physicians can be found at **www.MyHealthToolkitLA.com/links/FMOLHS** and by calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact **askHR@fmolhs.org** or call (833) 482-7547.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Legal Notices

Additional Notices continued

Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually see, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

We encourage you to determine if independent healthcare professionals are participating in the Plan by checking the Plan's website at www.MyHealthToolkitLA.com/links/FMOLHS and/or calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call (833) 482-7547.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services (HHS) at 1-800-985-3059.

Visit: **https://www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

Legal Notices

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, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: https://www.myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 1-916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Legal Notices

GEORGIA – Medicaid	LOUISIANA – 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
INDIANA – Medicaid	**MAINE – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	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
IOWA – Medicaid and CHIP (Hawki)	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
KANSAS – Medicaid	**MINNESOTA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KENTUCKY – Medicaid	**MISSOURI – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Legal Notices

MONTANA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
NEBRASKA – Medicaid	**OREGON – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
NEVADA – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
NEW HAMPSHIRE – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
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. 5218	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
NEW JERSEY – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW YORK – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH CAROLINA – Medicaid	**TEXAS – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH DAKOTA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

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VERMONT– Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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)
VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WASHINGTON – Medicaid	**WYOMING – Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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)

Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Profession Form Approved
OMB No. 1210-0149 (expires 11-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Legal Notices

*** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

** An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*