Sheppard Pratt
HEALTH SYSTEM
We help. You heal.

Sheppard Pratt Health System
Group Health Plan Enrollment Guide
Plan Year 2018/2019

Essential Information:

- **Review your Enrollment Guide carefully to understand all your options**
- **Eligible dependent children are eligible for medical, dental and vision until age 26.**
- **Health FSAs & Dependent FSAs; you must submit all claims no later than September 30 after the end of the plan year (July 1st - June 30th)**
- **You may purchase life insurance & AD&D for your spouse and eligible dependents**
- **Go to the enrollment website, www.sphsbenefits.com to choose benefit elections for plan year 2018-19. Enrollment instructions on page 50**
- **This is the only chance to elect or make changes to your benefits until the next open enrollment, unless you have a qualifying family status change**
- **Please review your elections for accuracy.**
- **Follow the instructions for the Wellness Program Discount, see pages 52-53**
- **Complete beneficiary forms. See forms on SPECS and enrollment website.**
- **Please see Human Resources if you need a paper version of this guide.**

The explanation of benefits in this guide is only intended as an overview. If any information differs from the plan contract, the plan contract will prevail. You are encouraged to review all of the changes carefully before making your final decisions.

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CONTACTS

Allegeant, LLC Claims and Service ***CareFirst BlueCross BlueShield Network*** (within MD/DC/Northern VA) ***PHCS*** ~ participating providers outside the CareFirst BlueCross BlueShield service area	Toll Free: 1.800.553.8635 Email: customercare@allegeant.net Network Provider Directory:www.carefirst.com 1.800.678.7427 or www.phcs.com
Allegeant, LLC/Informed Medical Management Services Precertification/case management	1.866.397.1698
Allegeant, LLC Wellness Coordinator: Kathy Harris	410.605.0007 x 7190 kharris@allegeant.net www.allegeant.net
Baltimore County Federal Employees Credit Union	1.800.234.4730 www.BCEFCU.com
Discovery Benefits Flexible Spending & Health Savings Accounts	1.866.451.3399 www.discoverybenefit.com customerservice@discoverybenefits.com participant services fax: 1.866.451.3245
Division of Human Resources Towson Campus	410.938.3300
GoodRx	http://sheppardpratt.goodrx.com
Kelly and Associates Insurance Group Call Center	410.891.2655 Toll Free: 1.800.733.8166
KEPRO / Employee Assistance Program ***Company Code: SPHS***	1.800.765.0770 Service available 24 hours a day www.eaphelplink.com
MagellanRx ***Prescription Plan* (For all Health Plans)** Group: 00SPHS01	Customer Service: 1.800.424.5828 For prior authorizations use option 4
MetLife Group number: 0215096	Customer Service: 1-800-GET MET8 https://mybenefits.metlife.com/
Sheppard Pratt Health System Plan Enrollment Website & Resource Center	www.sphsbenefits.com
Transamerica Retirement Solutions 403(b) Tax Sheltered Annuity & Thrift Plans	Toll Free: 1.888.676.5512 www.trsretire.com
United Concordia Dental Plans PPO Plan – Advantage Plus Network PPO Group – 882572-000 DMO Plan – Concordia Plus Network DMO Group – 882573-000	PPO Toll Free: 1.800.332.0366 DMO Toll Free: 1.866.357.3304 www.ucci.com
Vision Service Plan **Group: 6107517**	Toll Free: 1.800.877.7195 www.vsp.com

SHEPPARD PRATT HEALTH SYSTEM GROUP HEALTH PLAN

Sheppard Pratt is pleased to offer a benefits package that is designed to meet the needs of our employees, and contributes significantly toward the cost of these benefits. We are confident that you will find suitable coverage at a reasonable cost.

ELIGIBILITY FOR BENEFITS

- A newly hired employee must be hired into a position that is budgeted for at least 30 hours per week to be eligible to receive benefits.
- A current employee must remain in a position that is budgeted for at least 30 hours per week to remain eligible for benefits

Consult your supervisor or Human Resources if you are unsure about your eligibility for benefits.

Benefits will begin the first day of the month following 30 days of continuous employment or transfer to a benefit eligible position. **You must enroll within 31 days from the *date of hire or transfer* to a benefit eligible position.** If you do not enroll within 31 days, you must wait until the next open enrollment period, unless there is a qualifying change in family status or event.

The Average Hour Calculation measurement is conducted on an annual basis in April/May to determine benefit eligibility for the following plan year. Employees MUST maintain an average of at least 30 hours per week to remain eligible for benefits.

*Eligibility will be determined for benefits as follows:

Average Hour Calculation:

***New Employees:**

- The Average Hour Calculation measurement will be completed at the new employee's anniversary date to determine eligibility for benefits if not determined upon hire
- After the new employee's anniversary Average Hour Calculation, the Average Hour Calculation measurement will be conducted on an annual basis in April to determine eligibility for the following plan year. **Employees MUST maintain an average of at least 30 hours per week to remain eligible for benefits.**

***Current Employees: The hours of current employees will be measured by using a look back period to determine "Average Hours"**

- Employees who maintained an average of at least 30 hours per week will be eligible to enroll for benefits and will continue to receive PTO and/or PL
- Employees who DID NOT maintain an average of at least 30 hours per week will be NOT be eligible to enroll for benefits and will also lose eligibility for PTO and/or PL. (These employees would be eligible for COBRA if losing coverage from the health plans)
- Time spent on an approved Family and Medical Leave (FMLA), military leave or jury duty **will** count towards the average hour calculation as long as the hours are reported properly
- Once FMLA time is exhausted, disability hours paid by our disability carrier **will NOT** count towards the average hour calculation
- PTO, PL and Sick Leave pay hours **will** count towards the average hour calculation

*This process is based on the provisions of the Affordable Care Act (ACA) and is subject to change as necessary based on revisions of the ACA.

HEALTH PLAN OPTIONS

Benefit eligible employees may select from three medical plan coverage options, two dental plans, and a vision plan. Sheppard Pratt offers Life Insurance (1x salary) and disability benefits (60% of salary) as core benefits at a minimal cost to the employee. Optional life insurance is also available, as well as accidental death coverage (AD &D).

Our Group Health Plans - Three Levels Of Coverage – Choose What Is Best For You!

- **Standard Plan** – a plan designed to meet the basic health care needs of our employees for a reasonable rate
- **Premium Plan** – a plan with expanded benefits with an additional cost for this coverage
- **High Deductible Plan** – a plan that is less costly per pay but has a higher deductible when used

Our group health plans are administered by Allegeant, LLC, and offer the services provided by participating providers in the **CareFirst BlueCross BlueShield Preferred** (MD, DC and Northern VA). The plans offer both an in-network and out-of-network option. You receive the highest level of benefits from an in-network provider, but may also receive care from any provider who is outside the network.

- For a complete list of network providers, please visit the CareFirst BCBS website at www.carefirst.com go to the "find a doctor" page, choose CareFirst-Network Leasing under "Other Sites."
- For a participating provider and services incurred outside the health plan's service area (MD, DC, & No. VA) contact **PHCS** at 800.678.7427, or visit www.phcs.com for in network coverage.

For claims services, see the myAllegeant internet access page in this guide.

MagellanRx - Prescription Drug Plan

Sheppard Pratt's prescription drug coverage is administered by **MagellanRx** which offers more than 60,000 pharmacies, representing major chain regional pharmacies and independent stores as well as a mail-order program. **MagellanRx** provides 24/7 customer service at **800.424.5828**, or through their website at **www.magellanrx.com**.

Magellan Rx Prescription Drug Card	**Co-payment per Prescription**	
	Retail 34 day supply	**Mail Order 90 day supply**
Generic drugs	$5	$10
Brand Name Preferred Drugs	$30	$60
Brand Name Non-Preferred Drugs	$60	$120
Specialty Drugs	20% coinsurance up to a $100 Maximum	
Antidiabetic, Antihypertensive and Antihyperlipidemic Preventive Generic Drugs	$0	
Approved Over-the-Counter (OTC) Drugs	$0 (Requires prescription from physician)	
Under the High Deductible Plan, all prescription drug expenses are subject to the Medical Plan's deductible amount. After a Member's deductible has been satisfied, the prescription co-payments will apply for the remainder of the Plan year or until the Out-of-Pocket maximum has been satisfied. *After the Out-of-Pocket maximum has been met, prescriptions will be paid in full for the remainder of the Plan year.*		

MagellanRx helps manage the growing cost of prescription drugs:
The following prescription drug programs have been implemented to promote the use of safe, cost-effective and clinically appropriate medications programs help to ensure that, for select prescription medications, members use these medications in the most effective way and also help us to manage medication costs.

- **Brand Name Preferred (Drug List or Formulary**) - the available list of prescription drugs continuously changes with some drugs previously on the list being eliminated and some not previously on the list added. Please speak to your physician about possible alternatives for medications that are not available at the Brand Name Preferred or Generic co pays.
- **Co-pays for Brand Name Non-Preferred Prescription Drugs -** are $60 (Retail -up to 34 day supply) and $120 (Mail Order - up to 90 day supply)
- **Prior Authorization -** Your physician must obtain approval to prescribe medications subject to Prior Authorization.
- **Quantity Limits -** For certain medications, there may be a limit to the amount of the medication that will be covered per prescription or for a defined period of time
- **Step Therapy Program -** may require you to first try one medication to treat your condition before another medication for that same condition will be covered.

You can inquire about these programs and the included prescription medications in these programs by looking in the Formulary list on www.magellanrx.com, or by calling **MagellanRx** Customer Service at **800.424.5828**.

Want to Save Money? Go Over-the-Counter (OTC)!

- Our prescription drug plan covers certain Over-the-Counter (OTC) medications with $0 co pay required when prescribed by your physician ($0 co pay after deductible if you are enrolled in the High Deductible Plan).
- Covered OTC medications include ulcer/gastrointestinal and non-sedating antihistamine/allergy medications Claritan®, Prevacid® 24HR, Prilosec OTC® and Zyrtec®.
- In consultation with your physician, you might want to consider an OTC product as it may be a lower cost, reasonable therapeutic alternative.

Sheppard Pratt employees enrolling for Medical and Prescription Drug coverage should refer to the www.sphsbenefits.com enrollment website for a Magellan Rx brochure that includes information about the prescription drug plan and a preferred drug list.

Dental and Vision

- Two Dental (PPO & DHMO) and Vision plans are available for employees who wish to elect this coverage. Effective July 1, 2018, dependent children are covered through age 26.

Life Insurance

- Sheppard Pratt provides basic group life insurance coverage at 1 times the employee's salary
- Employees may purchase additional life insurance (optional) up to 1 times the employee's salary
- Employees may purchase life insurance for their spouse and eligible dependents.

Accidental Death and Dismemberment

- Sheppard Pratt offers optional accidental death and dismemberment coverage up to 2 times the employee's salary
- Employees may purchase AD&D for their spouse and eligible dependents once they have purchased the life insurance for their spouse and eligible dependents

Disability Income Plan

- Employees receive income replacement provided through Sheppard Pratt's Disability Plan at a minimal cost, should he/she become totally disabled due to a non-occupational sickness or injury.

Medical Flexible Spending Account (FSA)

- Employees may elect to enroll in a Flexible Spending Account to pay for eligible out of pocket health care expenses. Limit is $2650.
- Employees electing a Flexible Spending Plan receive a debit card to use for accessing the funds in this plan

Dependent Care Flexible Spending Account (FSA)

- Employees may elect to enroll in a Flexible Spending Account to pay for eligible out of pocket dependent care expenses for eligible dependents through the age of 12. Limit is $5000.

Health Savings Account (HSA)

- Employees electing the High Deductible plan and who are eligible to open an Health Savings Account will be provided money from Sheppard Pratt ($500 for individual/$1000 if the employee elects dependent coverage) to be placed into this account to offset eligible health care expenses
- Employees may elect to deposit additional pretax dollars through payroll deduction into this plan up to the maximum amount allowed of $3,450 for an individual and $6,900 for a family
- Employees electing a Health Savings Account receive a debit card to use for accessing the funds in this plan

Wellness

Administered by **Allegeant, LLC**; services include:

- Dedicated Wellness Coordinator with added resources to help employees achieve better health
- Discounts for tobacco-free employees and for employees who complete the annual identified requirements

Family Coverage Levels

Employees can choose from six different family coverage levels:

Employee Only	Employee/Family
Employee/Child	Employee and Domestic Partner *
Employee/Spouse	Employee, Domestic Partner, and Employee's Children *

*Please see a Human Resources Representative to discuss the tax implications of these options.

Sheppard Pratt Health Plan Eligible Dependents:

- Your Spouse
- Eligible dependent children to age 26, regardless of marital or student status for group health, dental and vision plans
- Any dependent child who is mentally or physically incapable of self-support; no age limit
- Any person whose legal welfare is the legal responsibility of an employee pursuant to legal guardianship, written divorce settlement, written separation agreement, or court order

Dependent Eligibility Verification

- Employees are required to verify all of their dependent(s)' eligibility when enrolling in any of the benefit plans through required documentation (original birth and /or marriage certificate and previous year's tax returns (all income masked)
- Dependents will be removed from the plans if documentation is not received within 30 days from their eligibility date.
- Any employee not sure of their dependent(s)' eligibility should contact Human Resources

You will find the Summary Plan Descriptions (SPD) for all plans on the Sheppard Pratt Enrollment site, www.sphsbenefits.com in the Resource Library. The SPD of a Plan gives you details that have not been described in the above summary. Should you prefer a paper copy, contact the Benefits Department in the Division of Human Resources at 410.938.3376.

Qualifying Health Plan Changes

Benefit selections remain in effect during the Plan Year (July 1 through June 30). Changes during the Plan Year can be made only if a qualifying family status change or qualifying event occurs. You must notify the Division of Human Resources, Benefits Department, within 31 days of the family status change or qualifying event, and benefit changes will become effective on the date of change provided by the employee.

A family status change or qualifying event includes:

- A marriage or divorce
- The birth or adoption of a child
- The death of a spouse or dependent
- A change in your family status resulting from the loss of a dependent's eligible status
- The termination or commencement of your spouse's employment
- A significant increase or decrease in your work hours
- A leave of absence
- The loss of coverage for you or your spouse due to your spouse's employment

Any new election resulting from a change in work hours or other family status change or qualifying event must be consistent with the reason for the change.

DOMESTIC PARTNER COVERAGE IS AVAILABLE FOR ALL PLANS

Domestic Partners of Employees who meet the criteria below are eligible to be covered under the Sheppard Pratt health insurance plans. An employee wishing to buy such coverage must identify whether the Domestic Partner is a Qualified Dependent or not a Qualified Dependent as defined below and must complete, have notarized and return to Human Resources (Benefits Department) the ***Domestic Partner Affidavit*** within 31 days of the effective date**.** This form can be found on the Sheppard Pratt Enrollment Website **http://www.sphsbenefits.com** (Resource Center)**, SPECS,** or by contacting Human Resources.

An annual certification of this Affidavit is required; due by June 1st.

Definition / Eligibility

An individual (either of the same or opposite sex) who is in a committed, long-term, exclusive relationship with, and who currently lives with the Employee, and has done so continuously for ***six (6) months***, and meets at least **two** of the following criteria is considered a Domestic Partner:

- The Employee has granted his or her Domestic Partner powers under a durable power of attorney, or the Domestic Partner had the Employee power under a durable power of attorney
- The Employee has named his or her Domestic Partner as a beneficiary on his or her life insurance policy, or the Domestic Partner had named the Employee as a beneficiary on his or her life insurance policy
- The Employee and Domestic Partner have a joint bank account or joint credit cards
- The Employee and Domestic Partner have joint ownership or occupancy of real property such as a joint deed, joint mortgage or joint lease
- The Employee and Domestic Partner are named on the same car insurance

A Domestic Partner **cannot** be a child, parent, sibling or other blood relation of an Employee, which would bar marriage. **Supporting documents showing that at least two of the criteria have been satisfied must be attached to the Domestic Partner Affidavit**.

Domestic Partners Who Are Qualified Dependents

If the Employee's Domestic Partner is also the Employee's "Dependent" (as defined by the IRS), the Domestic Partner will be a Qualified Dependent and the premiums can be deducted on a pre-tax basis (meaning not subject to income and employment taxes). **An Employee and Domestic Partner who assert a Qualified Dependent status must provide satisfactory proof of such a relationship**. Sheppard Pratt is not in a position to and will not provide tax advice on this question. In general, the following must be met in order for the Domestic Partner to be a Qualified Dependent and for medical deductions to be made on a pre-tax basis:

- The Employee provides more than half of the Domestic Partner's support for the taxable year
- The Domestic Partner's principal place of abode is the Employee's home, and the Domestic Partner is a member of the Employee's household and meets the IRS definition of dependent

Domestic Partners who are dependents are eligible for reimbursement under the Health Flexible Spending Accounts. All Qualified Dependent status claims are subject to verification by Sheppard Pratt Health System.

Domestic Partners Who Are Not Qualified Dependents

The portion of the medical, dental and vision premium for coverage of the Domestic Partner who is not a Qualified Dependent of an Employee will be deducted on a taxable basis, according to the IRS. **This means that the Employee will pay income and employment taxes on the fair market value of this part of his/her total coverage. In addition, the added Sheppard Pratt cost for the Domestic Partner is treated as imputed income to the Employee.** Please see Human Resources for more details on the tax cost implication of a particular benefit choice. Domestic Partners who are not Qualified Dependents are not eligible for reimbursement under the Health Flexible Spending Accounts.

SUMMARY OF STANDARD, PREMIUM AND HIGH DEDUCTIBLE PLANS

(Please note that this Schedule is merely a summary of some of the features of the Plans. Please refer to the Summary Plan Description for details and description of benefits.)

SERVICE	STANDARD PLAN		PREMIUM PLAN		High Deductible Plan	
	CAREFIRST BLUE CROSS BLUE SHIELD IN-NETWORK	OUT OF NETWORK****	CAREFIRST BLUE CROSS BLUE SHIELD IN-NETWORK	OUT OF NETWORK***	CAREFIRST BLUE CROSS BLUE SHIELD IN-NETWORK	OUT OF NETWORK***
Annual Deductible*	$300 per Individual $600 per Family	$600 per Individual $1,200 per Family	$150 per Individual $300 per Family	$500 per Individual $1,000 per Family	$2,000 per Individual $4,000 per Family	$4,000 per Individual $8,000 per Family
Out of Pocket Maximum**	$3,000 per Individual $6,000 per Family	$6,000 per Individual $12,000 per Family	$2,500 per Individual $5,000 per Family	$6,000 per Individual $12,000 per Family	$4,000 per Individual $8,000 per Family	$8,000 per Individual $16,000 per Family
Annual Maximum per Person Unlimited						
Office Sick Visits	$20 PCP/$40 Specialist (all services such as x-ray or lab billed by the same provider on same day as sick visit covered at 100% of AB (AB = Allowed Benefit)	60%/Deductible	$20 PCP/$40 Specialist (all services such as x-ray or lab billed by the same provider on same day as sick visit covered at 100% of AB (AB = Allowed Benefit)	70%/Deductible	$20 PCP/$40 Specialist/Deductible	60%/Deductible
Well Care Office Visits	100% of AB	Not Covered	100% of AB	Not Covered	100% of AB	Not Covered
Well Care Services (Preventive Services, Screenings)	100% of AB	Not Covered	100% of AB	Not Covered	100% of AB	Not Covered
Outpatient Diagnostic Services	80% of AB/Deductible	60% /Deductible	$20 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Outpatient MRI, CAT scan, Pet scan	80% of AB/Deductible	60% /Deductible	$100 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Outpatient Hospitalization						
Surgery (facility)	80% of AB/Deductible	60% /Deductible	$50 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Emergency Room	$150 copay, 80% of AB	$150 copay, 80% of AB	$150 copay, 100% of AB	$150 copay, 100% of AB	100%/Deductible	100%/Deductible
Preadmission Testing	80% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Chemotherapy/Radiation	80% of AB/Deductible	60% /Deductible	$50 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Outpatient/Surgeon/Anesthesiologist	80% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Inpatient Hospitalization						
Inpatient Hospital Services	90% of AB/Deductible	60% /Deductible	$500 copay, then 100% of AB/Deductible	$500 copay, 70%/Deductible	100%/Deductible	60%/Deductible
Nursery	90% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Consultation	80% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Surgeon/Anesthesiologist	80% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Second Surgical Opinion	100% of AB/Deductible	100% /Deductible	100% of AB/Deductible	100%/Deductible	100%/Deductible	60%/Deductible
Ambulance Service	80% of AB/Deductible	80% /Deductible	100% of AB/Deductible	100%/Deductible	100%/Deductible	100%/Deductible
Mental Health-Inpatient***	90% of AB/Deductible	60% /Deductible	$500 copay, then 100% of AB/Deductible	$500 copay, 70%/Deductible	100%/Deductible	60%/Deductible
Mental Health-Partial Hospitalization***	90% of AB/Deductible	60% /Deductible	$50 copay per day up to $500, then 100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Mental Health-Outpatient***	80% of AB/Deductible	60% /Deductible	$20 PCP/$40 Specialist	70%/Deductible	100%/Deductible	60%/Deductible
Home Health Visits	100% for 40 visits	60% /Deductible/40 visits	100% for 40 visits	70%/Deductible/40 visits	100%/Deduct/40visits	60%/Dedutible/40visits
Convalescent Hospital	100% for 60 days/Deductible	60% /Deductible/60 days	100% for 60 days/Deductible	70%/Deductible/60 days	100%/Deduct/60days	60%/Deductible/60days
Hospice Care-Inpatient	100% for 30 days	60% /Deductible/30 days	100% for 30 days	70%/Deductible/30 days	100%/Deduct/30days	60%/Deductible/30days
Hospice Care-Outpatient	100% of AB	60% /Deductible	100% of AB	70%/Deductible	100%/Deductible	60%/Deductible
Physical or Speech Therapy (combined annual max of 60 visits)	80% of AB/Deductible	60% /Deductible	$40 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Acupuncture	80% of AB/Deductible	60% /Deductible	$40 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Diabetes Education	80% of AB/Deductible	60% /Deductible	100% of AB/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Chiropractic Services (annual maximum of 10 visits)	80% of AB/Deductible	60% /Deductible	$40 copay/Deductible	70%/Deductible	100%/Deductible	60%/Deductible
Prescription Drug	Retail/Mail: $5-$30-$60/$10-$60-$120 (Generic, Preferred, non-Preferred). Specialty Drugs: 20% copay up to $100 maximum Approved Over-the-Counter (OTC) Drugs: $0 copay (requires prescription from physician) Out of Pocket Maximum: $3,000 per Individual, $7,000 per Family		Retail/Mail: $5-$30-$60/$10-$60-$120 (Generic, Preferred, non-Preferred). Specialty Drugs: 20% copay up to $100 maximum. Approved Over-the-Counter (OTC) Drugs: $0 copay (requires prescription from physician) Out of Pocket Maximum: $3,000 per Ind., $7,000 per Family		Deductible then: Retail/Mail: $5-$30-$60/$10-$60-$120 (Generic, Preferred, non-Preferred). Specialty Drugs: 20% copay up to $100 maximum. Approved Over-the-Counter (OTC) Drugs: $0 copay (requires prescription from physician)	

* *Deductible and out-of-pocket maximum are met on the Plan Year (July 1- June 30). ** Out-of-pocket maximum excludes penalties and amounts over R&C charges*

*** *Applicable Copay or coinsurance for inpatient and outpatient network benefits will be waived with SPHS, SPPPA, Family Services Inc., Mosaic Community Services or Way Station, Inc. mental health providers*

**** *Out-of-Network expenses will be reimbursed at the Plan's Allowable Amount. Note: All benefits are subject to applicable utilization review.*

EMERGENCY ROOM OR URGENT CARE?

If you're faced with a sudden illness or injury, making an informed choice on where to seek **medical care** is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. In fact, Harvard University reported that 62 percent of personal bankruptcies are caused by medical expenses, making medical debt the leading cause of bankruptcy in America.

If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition?

Emergency Room

Vs.

Urgent Care

The **emergency room (ER)** is equipped to handle life-threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.

You should go to the nearest ER if you experience any of the following:

- Compound fractures
- Deep knife or gunshot wounds
- Moderate to severe burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries
- Severe abdominal pain
- Severe chest pain or difficulty breathing
- Signs of a heart attack or stroke
- Suicidal or homicidal feelings
- Uncontrollable bleeding

Urgent care centers are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.

Some example of conditions that require a visit to an urgent care center include:

- Controlled bleeding or cuts that require stitches
- Diagnostic services (X-rays, lab tests)
- Ear infections
- High fever or the flu
- Minor broken bones (e.g., toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes and infections
- Urinary tract infections
- Vomiting, diarrhea or dehydration

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although urgent care centers are usually more cost-effective, they are **not** a substitute for emergency care.

Allegeant℠
Accountable Care Solutions

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the standard) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (410) 938-3311. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (410) 938-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$300** individual/**$600** family Out-of-Network Providers **$600** individual/**$1,200** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Emergency Room Services, Home Health, Hospice and services where a copay is required.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical In-Network Providers **$3,000** individual/ $**6,000** family Medical Out-of-Network Providers **$6,000** individual/ $**12,000** family Prescription Drug (separate) **$3,000** individual/**$7,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Network providers see **www.carefirst.com** for MD, DC & No. VA only or **www.multiplan.com** click PHCS for all other areas.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit ▯ Renal Dialysis ▯ Chemotherapy ▯ Radiation Therapy ▯ Chiropractic Care ▯ Acupuncture ☐ Physical, Speech & Occupational Therapy	20% coinsurance	40% coinsurance	Prenotification required for Renal Dialysis, Chemotherapy and Radiation Therapy; Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

For more information about limitations and exceptions, see Summary Plan Description at www.sphsbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com.	Generic drugs (Tier 1)	$5 copay per retail prescription and $10.00 copay per mail order prescription, deductible does not apply	$5 copay per retail prescription and $10.00 copay per mail order prescription, deductible does not apply	Retail prescriptions are limited to a 34 day supply. Mail order prescriptions are limited to a 90 day supply. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay.
	Preferred brand drugs (Tier 2)	$30 copay per retail prescription and $60.00 copay per mail order prescription, deductible does not apply	$30 copay per retail prescription and $60.00 copay per mail order prescription, deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$60 copay per retail prescription and $120.00 copay per mail order prescription, deductible does not apply	$60 copay per retail prescription and $120.00 copay per mail order prescription, deductible does not apply	
	Specialty drugs (Tier 4)	20% coinsurance up to a $100 maximum per prescription	20% coinsurance up to a $100 maximum per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
If you need immediate medical attention	Emergency room care	$150 copay/visit 20% coinsurance; deductible does not apply	$150 copay/visit, 20% coinsurance; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$40 copay/visit; deductible does not apply	40% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Deductible and Coinsurance waived if care is provided by SPHS, SPPPA, Family Services Inc., Mosaic Community Services or Way Station, Inc. mental health providers. Prenotification required for intensive outpatient services.
	Inpatient services	10% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	20% coinsurance	40% coinsurance	No charge for breast feeding equipment. Prenotification required after $2,500 per plan year.
	Hospice services	No charge	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 30 days during 12 consecutive months.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Vision Plan available

Excluded Services & Other Covered Services:

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

- Abortion (unless mother's life/health is at risk)
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Holistic or Homepathic medicine
- Infertility Treatment
- Long Term Care
- Maternity care for dependent children/adults
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Allegeant, (800) 553-8635. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

For more information about limitations and exceptions, see Summary Plan Description at www.sphsbenefits.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 553-8635.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 553-8635.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码(800) 553-8635.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 553-8635.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$300
Specialist copayment	$0
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,580
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$790
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$120
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (410) 938-3311. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (410) 938-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$150** individual/**$300** family Out-of-Network Providers **$500** individual/**$1,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overallfamily deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Emergency Room Services, Urgent Care Centers, PCP & Specialist Office Visits, Home Health & Hospice	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical In-Network Providers **$2,500** individual/ $**5,000** family Medical Out-of-Network Providers **$6,000** individual/ $**12,000** family Prescription Drug (separate) **$3,000** individual/**$7,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Network providers see **www.carefirst.com** for MD, DC & No. VA only or **www.multiplan.com** click PHCS for all other areas.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	30% coinsurance	None.
	Specialist visit	$40 copay/visit; deductible does not apply	30% coinsurance	None.
	Specialist visit • Renal Dialysis • Chemotherapy • Radiation Therapy • Chiropractic Care • Acupuncture • Physical, Speech & Occupational Therapy	$50 copay/visit, 0% coinsurance for Chemotherapy, Radiation Therapy and Renal Dialysis, deductible does not apply $40 copay/visit, 0% coinsurance for all other office visits, deductible does not apply	30% coinsurance	Prenotification required for Renal Dialysis, Chemotherapy and Radiation Therapy; Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit, 0% coinsurance	30% coinsurance	All outpatient locations.
	Imaging (CT/PET scans, MRIs)	$100 copay/visit, 0% coinsurance	30% coinsurance	

For more information about limitations and exceptions, see Summary Plan Description at www.sphsbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com.	Generic drugs (Tier 1)	$5 copay per retail prescription and $10.00 copay per mail order prescription, deductible does not apply	$5 copay per retail prescription and $10.00 copay per mail order prescription, deductible does not apply	Retail prescriptions are limited to a 34 day supply. Mail order prescriptions are limited to a 90 day supply. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay.
	Preferred brand drugs (Tier 2)	$30 copay per retail prescription and $60.00 copay per mail order prescription, deductible does not apply	$30 copay per retail prescription and $60.00 copay per mail order prescription, deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$60 copay per retail prescription and $120.00 copay per mail order prescription, deductible does not apply	$60 copay per retail prescription and $120.00 copay per mail order prescription, deductible does not apply	
	Specialty drugs (Tier 4)	20% coinsurance up to a $100 maximum per prescription	20% coinsurance up to a $100 maximum per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/per admit, 0% coinsurance	30% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible does not apply	$150 copay/visit, deductible does not apply	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	$40 copay/visit; deductible does not apply	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/per admit, 0% coinsurance	$500 copay per admit, 30% coinsurance	Precertification required. $1,000 penalty for non-precertification.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit	30% coinsurance	Deductible and Coinsurance waived if care is provided by SPHS, SPPPA, Family Services Inc., Mosaic Community Services or Way Station, Inc. mental health providers. Prenotification required for intensive outpatient services. Partial hospitalization $50 copay per day up to $500.
	Inpatient services	$500 copay/per admit, 0% coinsurance	$500 copay/per admit, 30% coinsurance	
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$500 copay/per admit, 0% coinsurance	$500 copay/per admit, 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	$40 copay/visit, 0% coinsurance	30% coinsurance	Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Habilitation services	$40 copay/visit, 0% coinsurance	30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	0% coinsurance	30% coinsurance	No charge for breast feeding equipment. Prenotification required after $2,500 per plan year.
	Hospice services	No charge	30% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 30 days during 12 consecutive months.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Vision Plan available

Excluded Services & Other Covered Services:

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

- Abortion (unless mother's life/health is at risk)
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Holistic or Homepathic medicine
- Infertility Treatment
- Long Term Care
- Maternity care for dependent children/adults
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Allegeant, (800) 553-8635. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

For more information about limitations and exceptions, see Summary Plan Description at www.sphsbenefits.com.

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

About these Coverage Examples:

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

The plan's overall deductible	$150
Specialist copayment	$0
Hospital (facility) copayment	$500
Other coinsurance	0%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$920
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,130**

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

The plan's overall deductible	$150
Specialist copayment	$40
Hospital (facility) copayment	$500
Other coinsurance	0%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$1,110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$150
Specialist copayment	$40
Hospital (facility) copayment	$50
Other coinsurance	0%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the high deductible) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (410) 938-3311. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (410) 938-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$2,000** individual/**$4,000** family Out-of-Network Providers **$4,000** individual/**$8,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription In-Network Providers **$4,000** individual/ **$8,000** family Out-of-Network Providers **$8,000** individual/ $**16,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Network providers see **www.carefirst.com** for MD, DC & No. VA only or **www.multiplan.com** click PHCS for all other areas.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; 0% coinsurance	40% coinsurance	None
	Specialist visit	$40 copay/visit; 0% coinsurance	40% coinsurance	None
	Specialist visit - Renal Dialysis - Chemotherapy - Radiation Therapy - Chiropractic Care - Acupuncture - Physical, Speech & Occupational Therapy	0% coinsurance	40% coinsurance	Prenotification required for Renal Dialysis, Chemotherapy and Radiation Therapy; Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com.	Generic drugs (Tier 1)	$5 copay per retail prescription and $10.00 copay per mail order prescription	$5 copay per retail prescription and $10.00 copay per mail order prescription	Retail prescriptions are limited to a 34 day supply. Mail order prescriptions are limited to a 90 day supply. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay.
	Preferred brand drugs (Tier 2)	$30 copay per retail prescription and $60.00 copay per mail order prescription	$30 copay per retail prescription and $60.00 copay per mail order prescription	
	Non-preferred brand drugs (Tier 3)	$60 copay per retail prescription and $120.00 copay per mail order prescription	$60 copay per retail prescription and $120.00 copay per mail order prescription	
	Specialty drugs (Tier 4)	20% coinsurance up to a $100 maximum per prescription	20% coinsurance up to a $100 maximum per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	$40 copay/visit; 0% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	40% coinsurance	Deductible and Coinsurance waived if care is provided by SPHS, SPPPA, Family Services Inc., Mosaic Community Services or Way Station, Inc. mental health providers. Prenotification required for intensive outpatient services.
	Inpatient services	0% coinsurance	40% coinsurance	
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	0% coinsurance	40% coinsurance	Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Habilitation services	0% coinsurance	40% coinsurance	
	Skilled nursing care	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	0% coinsurance	40% coinsurance	No charge for breast feeding equipment. Prenotification required after $2,500 per plan year.
	Hospice services	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 30 days during 12 consecutive months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Vision Plan available

For more information about limitations and exceptions, see Summary Plan Description at www.sphsbenefits.com.

Excluded Services & Other Covered Services:

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

- Abortion (unless mother's life/health is at risk)
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Holistic or Homepathic medicine
- Infertility Treatment
- Long Term Care
- Maternity care for dependent children/adults
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Allegeant, (800) 553-8635. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al (800) 553-8635.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 553-8635.
Chinese （中文): 如果需要中文的帮助， 请拨打这个号码(800) 553-8635.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 553-8635.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$2000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2120**

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

The plan's overall deductible	$2000
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2850**

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

The plan's overall deductible	$2000
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1810
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1930**

Sheppard Pratt Health System

Proposed Bi-Weekly Employee Rates - Health Plans

Plan Year: July 1, 2018 - June 30, 2019

Medical Plans:	Total Rate	Employee Non-Smoker Discount	Spouse Non-Smoker Discount	Wellness Program Employee Participation Discount	Total Discounted Rate
Premium Plan					
Employee	$128.08	-$15.24		-$15.24	$97.60
Employee + 1 Child	$221.21	-$15.24		-$15.24	$190.73
Employee + Spouse	$269.73	-$15.24	-$15.24	-$15.24	$224.01
Employee + Partner	$269.73	-$15.24	-$15.24	-$15.24	$224.01
Family	$346.23	-$15.24	-$15.24	-$15.24	$300.51
Employee + Partner + Child(ren)	$346.23	-$15.24	-$15.24	-$15.24	$300.51
Standard Plan					
Employee	$87.56	-$13.39		-$13.39	$60.78
Employee + 1 Child	$149.77	-$13.39		-$13.39	$122.99
Employee + Spouse	$185.38	-$13.39	-$13.39	-$13.39	$145.21
Employee + Partner	$185.38	-$13.39	-$13.39	-$13.39	$145.21
Family	$236.49	-$13.39	-$13.39	-$13.39	$196.32
Employee + Partner + Child(ren)	$236.49	-$13.39	-$13.39	-$13.39	$196.32
High Deductible Plan					
Employee	$48.31	-$9.55		-$9.55	$29.21
Employee + 1 Child	$78.40	-$9.55		-$9.55	$59.30
Employee + Spouse	$98.72	-$9.55	-$9.55	-$9.55	$70.07
Employee + Partner	$98.72	-$9.55	-$9.55	-$9.55	$70.07
Family	$123.45	-$9.55	-$9.55	-$9.55	$94.80
Employee + Partner + Child(ren)	$123.45	-$9.55	-$9.55	-$9.55	$94.80

Employer HSA contribution (for qualified participants enrolling in High Deductible Plan)

Employee ($500 for full Plan Year)	$20.83	(24 pays)
Employee w/Dependent coverage ($1,000 for full Plan Year)	$41.67	(24 pays)

	United Concordia Dental Plans		
	PPO Plan	**DMO Plan**	**VSP Vision Plan**
Employee	$6.05	$3.70	$3.14
Employee + 1 Child	$11.70	$7.28	$4.71
Employee + Children	n/a	$7.28	n/a
Employee + Spouse	$12.65	$7.37	$5.23
Employee + Partner	$12.65	$7.37	$5.23
Family	$17.40	$10.52	$6.27
Employee + Partner + Child(ren)	$17.40	$10.52	$6.27

4/3/18

Sheppard Pratt Health System

Bi-Weekly Employee Rates - Life Insurance and AD&D
New Carrier effective July 1, 2018: MetLife
Plan Year: July 1, 2018 - June 30, 2019

Life Insurance	Total Rate
Employee Basic Life Insurance 1 x Salary	Basic Life benefit provided by Sheppard Pratt
Employee Supplemental Life Insurance	
0.5 times Annual Salary	Annual Salary / 1000 x age-band rate x 0.5 x 12 / 26
1 times Annual Salary	Annual Salary / 1000 x age-band rate x 1.0 x 12 / 26
Supplemental AD&D Insurance	
1/2 times Annual Salary	Annual Salary / 1000 x .020 x 0.5 x 12 / 26
1 times Annual Salary	Annual Salary / 1000 x .020 x 12 / 26
1 1/2 times Annual Salary	Annual Salary / 1000 x .020 x 1.5 x 12 / 26
2 times Annual Salary	Annual Salary / 1000 x .020 x 2 x 12 / 26

- For July 1, 2018 enrollment, all employees, including those currently enrolled in Basic life only, may elect up to the lesser of $300,000 or 1.0 times annual salary without an approved Statement of Health.
- For future annual enrollments, employees already enrolled in 0.5 times Salary Supplemental Life may increase coverage up to the lesser of $300,000 or 1.0 times Salary without an approved Statement of Health. Employees enrolled in Basic Life only must have an approved Statement of Health to enroll in Supplemental Life.
- Guaranteed Issue is $500,000 for Basic Life and $300,000 for Supplemental Life.
- Basic Life has a maximum benefit of $500,0000. Supplemental Life has a separate maximum benefit of $1,000,000.
- Supplemental AD&D is a separate election from Supplemental Life and does not require enrollment in Supplemental Life.
- Employee Basic Life are reduced on and after age 70 by applying the appropriate percentage from the table table below to the amount of benefits in effect on the day before your 70th birthday. There is no age reduction for the Supplemental Life and Supplemental AD&D beneftis.

Age of Employee	Percent
70 but less than 75	65%
75 but less than 80	45%
80 or older	30%

Employee Supplemental Life Insurance Age-Band rates:

Age Band*	Monthly Rate per $1,000	Bi-Weekly Rate per $1,000
<25	$0.050	$0.023
25-29	$0.060	$0.028
30-34	$0.075	$0.035
35-39	$0.090	$0.042
40-44	$0.100	$0.046
45-49	$0.125	$0.058
50-54	$0.200	$0.092
55-59	$0.295	$0.136
60-64	$0.375	$0.173
65-69	$0.438	$0.202
70+	$0.500	$0.231

* Age is to be determined based on age as of July 1, 2018.

4/3/2018

Sheppard Pratt Health System

Bi-Weekly Employee Rates - Life Insurance and AD&D
New Carrier effective July 1, 2018: MetLife
Plan Year: July 1, 2018 - June 30, 2019

		Total Rate
Dependent Supplemental Life Insurance		
Spouse		
Flat $25,000		Benefit Amount / 1000 x age-band rate x 12 / 26
Child		
Child up to 6 months old:	$1,000	Benefit Amount / 1000 x 0.112 x 12 / 26
Child more than 6 months, but less than age 20 (less than age 24 if a full time student):	Flat $10,000	
Dependent Supplemental AD&D Insurance		
Spouse		
100% of the Spouse Supplemental Life benefit.		Benefit Amount / 1000 x 0.016 x 12 / 26
Child		
100% of the Child Supplemental Life benefit.		Benefit Amount / 1000 x 0.030 x 12 / 26

- For July 1, 2018 enrollment all employees may elect Dependent Supplemental Life Insurance without an approved Statement of Health.
- For future annual enrollments, dependents must have an approved Statement of Health to enroll in Dependent Supplemental Life.
- Guaranteed Issue is $25,000 for Spouse Supplemental Life and $10,000 for Child Supplemental Life.
- Employees' dependents must be enrolled in Dependent Supplemental Life in oder to enroll in Dependent Supplemental AD&D.

Spouse Supplemental Life Insurance Age-Band rates (based on employee's age):

Age Band*	Monthly Rate per $1,000	Bi-Weekly Rate per $1,000
<25	$0.040	$0.018
25-29	$0.040	$0.018
30-34	$0.047	$0.022
35-39	$0.064	$0.030
40-44	$0.086	$0.040
45-49	$0.127	$0.059
50-54	$0.200	$0.092
55-59	$0.363	$0.168
60-64	$0.681	$0.314
65-69	$1.168	$0.539
70+	$2.177	$1.005

* Age is to be determined based on age as of July 1, 2018.

4/3/2018

Sheppard Pratt Health System
Bi-Weekly Employee Rates - Disability Insurance Post-Tax Deductions
Plan Year: July 1, 2018 - June 30, 2019

Disability Insurance	Paid by SPHS: Added to W-2 Wages Deducted from Employee Pay
Hospital Employees	
Short Term Disability (60%)	Annual Salary x 0.00251 / 26
Long Term Disability (60%)	Annual Salary x 0.00383 / 26
SPPA Group (Physicians)	
Short Term Disability (60%)	Annual Salary x 0.01592 / 26
Long Term Disability (60%)	Annual Salary x 0.00383 / 26
School Schedule Employees	
Short Term Disability (60%)	Annual Salary x 0.00365 / 26
Long Term Disability (60%)	Annual Salary x 0.00383 / 26

Note: The Maximum Monthly Benefit for both Short Term and Long Term Disability is $20,000. Therefore, in calculating both the Short Term and Long Term Disability costs above, Annual Salary is capped at $400,000.

Sheppard Pratt Health System
School Schedule Employees - 21 Pay Periods
Proposed Bi-Weekly Employee Rates - Health Plans
Plan Year: July 1, 2018 - June 30, 2019

Medical Plans:	Total Rate	Employee Non-Smoker Discount	Spouse Non-Smoker Discount	Wellness Program Employee Participation Discount	Total Discounted Rate
Premium Plan					
Employee	$158.58	-$18.87		-$18.87	$120.84
Employee + 1 Child	$273.88	-$18.87		-$18.87	$236.14
Employee + Spouse	$333.95	-$18.87	-$18.87	-$18.87	$277.34
Employee + Partner	$333.95	-$18.87	-$18.87	-$18.87	$277.34
Family	$428.67	-$18.87	-$18.87	-$18.87	$372.06
Employee + Partner + Child(ren)	$428.67	-$18.87	-$18.87	-$18.87	$372.06
Standard Plan					
Employee	$108.41	-$16.58		-$16.58	$75.25
Employee + 1 Child	$185.43	-$16.58		-$16.58	$152.27
Employee + Spouse	$229.52	-$16.58	-$16.58	-$16.58	$179.78
Employee + Partner	$229.52	-$16.58	-$16.58	-$16.58	$179.78
Family	$292.80	-$16.58	-$16.58	-$16.58	$243.06
Employee + Partner + Child(ren)	$292.80	-$16.58	-$16.58	-$16.58	$243.06
High Deductible Plan					
Employee	$59.81	-$11.82		-$11.82	$36.17
Employee + 1 Child	$97.07	-$11.82		-$11.82	$73.43
Employee + Spouse	$122.22	-$11.82	-$11.82	-$11.82	$86.76
Employee + Partner	$122.22	-$11.82	-$11.82	-$11.82	$86.76
Family	$152.84	-$11.82	-$11.82	-$11.82	$117.38
Employee + Partner + Child(ren)	$152.84	-$11.82	-$11.82	-$11.82	$117.38

Employer HSA contribution (for qualified participants enrolling in High Deductible Plan)

Employee ($500 for full Plan Year)	$27.08	(20 pays)
Employee w/Dependent coverage ($1,000 for full Plan Year)	$54.17	(20 pays)

	United Concordia Dental Plans		
	PPO Plan	**DMO Plan**	**VSP Vision Plan**
Employee	$7.49	$4.58	$3.89
Employee + 1 Child	$14.49	$9.01	$5.83
Employee + Children	n/a	$9.01	n/a
Employee + Spouse	$15.66	$9.12	$6.48
Employee + Partner	$15.66	$9.12	$6.48
Family	$21.54	$13.02	$7.76
Employee + Partner + Child(ren)	$21.54	$13.02	$7.76

4/3/18

Sheppard Pratt Health System
School Schedule Employees - 21 Pay Periods
Bi-Weekly Employee Rates - Life Insurance and AD&D
Plan Year: July 1, 2018 - June 30, 2019

	Total Rate
Life Insurance	
Employee Basic Life Insurance 1 x Salary	Basic Life benefit provided by SPHS
Employee Supplemental Life Insurance	
0.5 times Annual Salary	Annual Salary / 1000 x age-band rate x 0.5 x 12 / 21
1 times Annual Salary	Annual Salary / 1000 x age-band rate x 1.0 x 12 / 21
Optional AD&D Insurance	
1/2 times Annual Salary	Annual Salary / 1000 x .020 x 0.5 x 12 / 21
1 times Annual Salary	Annual Salary / 1000 x .020 x 12 / 21
1 1/2 times Annual Salary	Annual Salary / 1000 x .020 x 1.5 x 12 / 21
2 times Annual Salary	Annual Salary / 1000 x .020 x 2 x 12 / 21

- For July 1, 2018 enrollment, all employees, including those currently enrolled in Basic life only, may elect up to the lesser of $300,000 or 1.0 times annual salary without an approved Statement of Health.
- For future annual enrollments, employees already enrolled in 0.5 times Salary Supplemental Life may increase coverage up to the lesser of $300,000 or 1.0 times Salary without an approved Statement of Health. Employees enrolled in Basic Life only must have an approved Statement of Health to enroll in Supplemental Life.
- Guaranteed Issue is $500,000 for Basic Life and $300,000 for Supplemental Life.
- Basic Life has a maximum benefit of $500,0000. Supplemental Life has a separate maximum benefit of $1,000,000.
- Supplemental AD&D is a separate election from Supplemental Life and does not require enrollment in Supplemental Life.
- Employee Basic Life are reduced on and after age 70 by applying the appropriate percentage from the table table below to the amount of benefits in effect on the day before your 70th birthday. There is no age reduction for the Supplemental Life and Supplemental AD&D beneftis.

Age of Employee	Percent
70 but less than 75	65%
75 but less than 80	45%
80 or older	30%

Employee Supplemental Life Insurance Age-Band rates:

Age Band*	Monthly Rate per $1,000	21 Pay Period Rate per $1,000
<25	$0.050	$0.029
25-29	$0.060	$0.034
30-34	$0.075	$0.043
35-39	$0.090	$0.051
40-44	$0.100	$0.057
45-49	$0.125	$0.071
50-54	$0.200	$0.114
55-59	$0.295	$0.169
60-64	$0.375	$0.214
65-69	$0.438	$0.250
70+	$0.500	$0.286

* Age is to be determined based on age as of July 1, 2017.

3/3/17

Sheppard Pratt Health System
School Schedule Employees - 21 Pay Periods
Bi-Weekly Employee Rates - Life Insurance and AD&D
New Carrier effective July 1, 2018: MetLife
Plan Year: July 1, 2018 - June 30, 2019

	Total Rate
Dependent Supplemental Life Insurance	
Spouse	
Flat $25,000	Benefit Amount / 1000 x age-band rate x 12 / 21
Child	
Child up to 6 months old: $1,000	Benefit Amount / 1000 x 0.112 x 12 / 21
Child more than 6 months, but less than age 20 (less than age 24 if a full time student): Flat $10,000	
Dependent Supplemental AD&D Insurance	
Spouse	
100% of the Spouse Supplemental Life benefit.	Benefit Amount / 1000 x 0.016 x 12 / 21
Child	
100% of the Child Supplemental Life benefit.	Benefit Amount / 1000 x 0.030 x 12 / 21

- For July 1, 2018 enrollment all employees may elect Dependent Supplemental Life Insurance without an approved Statement of Health.
- For future annual enrollments, dependents must have an approved Statement of Health to enroll in Dependent Supplemental Life.
- Guaranteed Issue is $25,000 for Spouse Supplemental Life and $10,000 for Child Supplemental Life.
- Employees' dependents must be enrolled in Dependent Supplemental Life in oder to enroll in Dependent Supplemental AD&D.

Spouse Supplemental Life Insurance Age-Band rates (based on employee's age):

Age Band*	Monthly Rate per $1,000	Bi-Weekly Rate per $1,000
<25	$0.040	$0.023
25-29	$0.040	$0.023
30-34	$0.047	$0.027
35-39	$0.064	$0.037
40-44	$0.086	$0.049
45-49	$0.127	$0.073
50-54	$0.200	$0.114
55-59	$0.363	$0.207
60-64	$0.681	$0.389
65-69	$1.168	$0.667
70+	$2.177	$1.244

* Age is to be determined based on age as of July 1, 2018.

4/3/2018

Sheppard Pratt Health System
School Schedule Employees - 21 Pay Periods
Bi-Weekly Employee Rates - Disability Insurance Post-Tax Deductions
Plan Year: July 1, 2018 - June 30, 2019

Disability Insurance	Paid by SPHS: Added to W-2 Wages Deducted from Employee Pay
School Schedule Employees	
Short Term Disability (60%)	Annual Salary x 0.00365 / 21
Long Term Disability (60%)	Annual Salary x 0.00383 / 21

Note: The Maximum Monthly Benefit for both Short Term and Long Term Disability is $20,000. Therefore, in calculating both the Short Term and Long Term Disability costs above, Annual Salary is capped at $400,000.

4/3/2018

Sheppard Pratt Health System
Monthly COBRA Rates
Plan Year: July 1, 2018 - June 30, 2019

	Medical Plans			Dental Plans		Vision Plan
	Premium Plan	Standard Plan	High Deductible Plan	PPO Plan	DMO Plan	VSP Plan
Employee	$666.54	$585.05	$416.61	$25.00	$16.28	$6.94
Employee + 1 Child	$1,225.91	$1,076.05	$766.12	$60.58	$32.13	$10.40
Employee + Children	n/a	n/a	n/a	n/a	$32.13	n/a
Employee + Spouse	$1,426.25	$1,251.92	$891.34	$63.46	$32.56	$11.56
Employee + Partner	$1,426.25	$1,251.92	$891.34	$63.46	$32.56	$11.56
Family	$1,885.73	$1,655.25	$1,178.46	$78.85	$46.48	$13.85
Employee+Partner+Child(ren)	$1,885.73	$1,655.25	$1,178.46	$78.85	$46.48	$13.85

* COBRA may also be elected for Flexible Spending Accounts.

Visit KELLYexchange.com to

- Learn about the Affordable Care Act and how the requirements affect you
- Determine if you qualify for financial assistance
- Shop and compare plans for individuals and families
- Choose and purchase the plan that best meets your needs and budget

It's fast, simple and affordable!

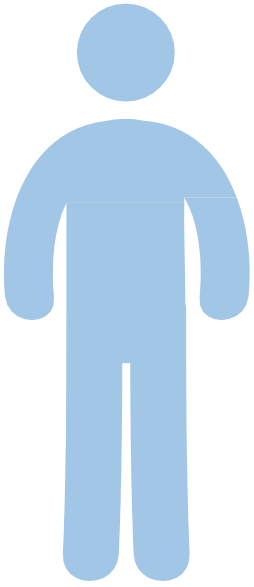
KELLYexchange.com | 1-877-YouExchange (968-3924)

KELLYexchange

Let's Get Digital

Simplifying healthcare through the use of technology

At Magellan Rx Management, we connect you to the tools and people you need to make better healthcare decisions. We make it easy to renew and refill prescriptions, compare medication pricing, access on-demand medication videos, and more!



Web

- Manage MailService Prescriptions
- Smart Pharmacy Locator ★
- View Claims History
- Check Drug Coverage
- Compare Drug Pricing ★
- Calculate Copay Options
- Formulary Listing
- View ID Card
- Access Health Resources & Forms
- Connect to Customer Service
- Medication Adherence Videos ★

Mobile

- Manage MailService Prescriptions
- Smart Pharmacy Locator ★
- View Claims History
- Check Drug Coverage
- Compare Drug Pricing ★
- Calculate Copay Options
- Formulary Listing
- View ID Card
- Access Health Resources & Forms
- Connect to Customer Service
- Medication Adherence Videos ★

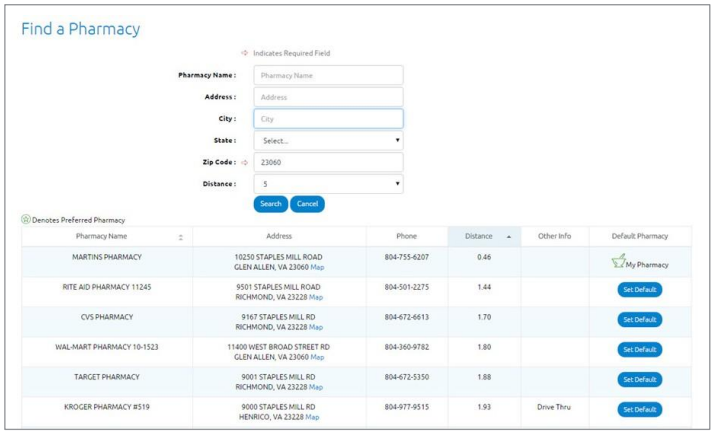
On Demand

- QR Codes on prescription labels for top-prescribed specialty & traditional medications
- Access medication videos
- Comprehensive digital medication & wellness library
- One-click nurse access
- Refill Reminders
- Order Scheduling & Tracking
- Real Time Alerts

No matter the digital resource, we are dedicated to offering you personalized service that improves outcomes and increases satisfaction.

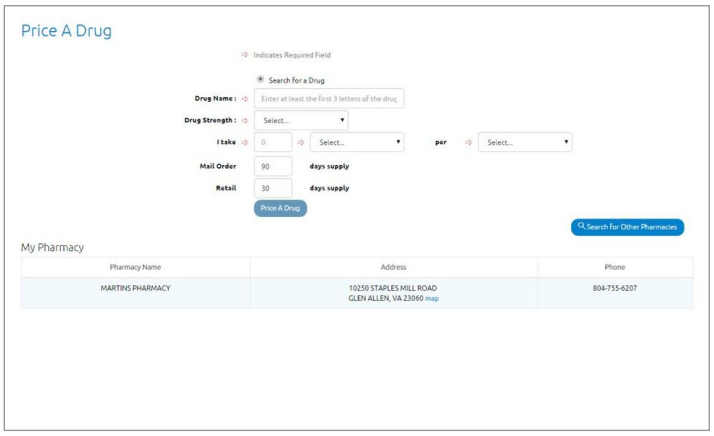
Experience a unique vision of care at magellanrx.com.

★ See reverse for screenshots and specifics



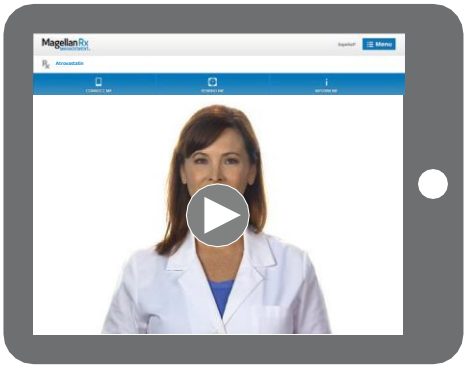
Smart Pharmacy Locator

- Locate pharmacies in your area
- Set default pharmacy



Price a Drug

- Auto-complete feature assists in searching for a drug
- Ability to select from previously filled drugs, and offer dosage and strength selections based on the drug selected
- Comparative drug pricing for up to 3 retail pharmacies
- Drug pricing messages are provided in clear, understandable language



Medication Videos

In an effort to empower our members with rich, relevant content for more informed healthcare decision-making, we now offer over 500 medication videos through our enhanced member portal. Our member portal videos provide:

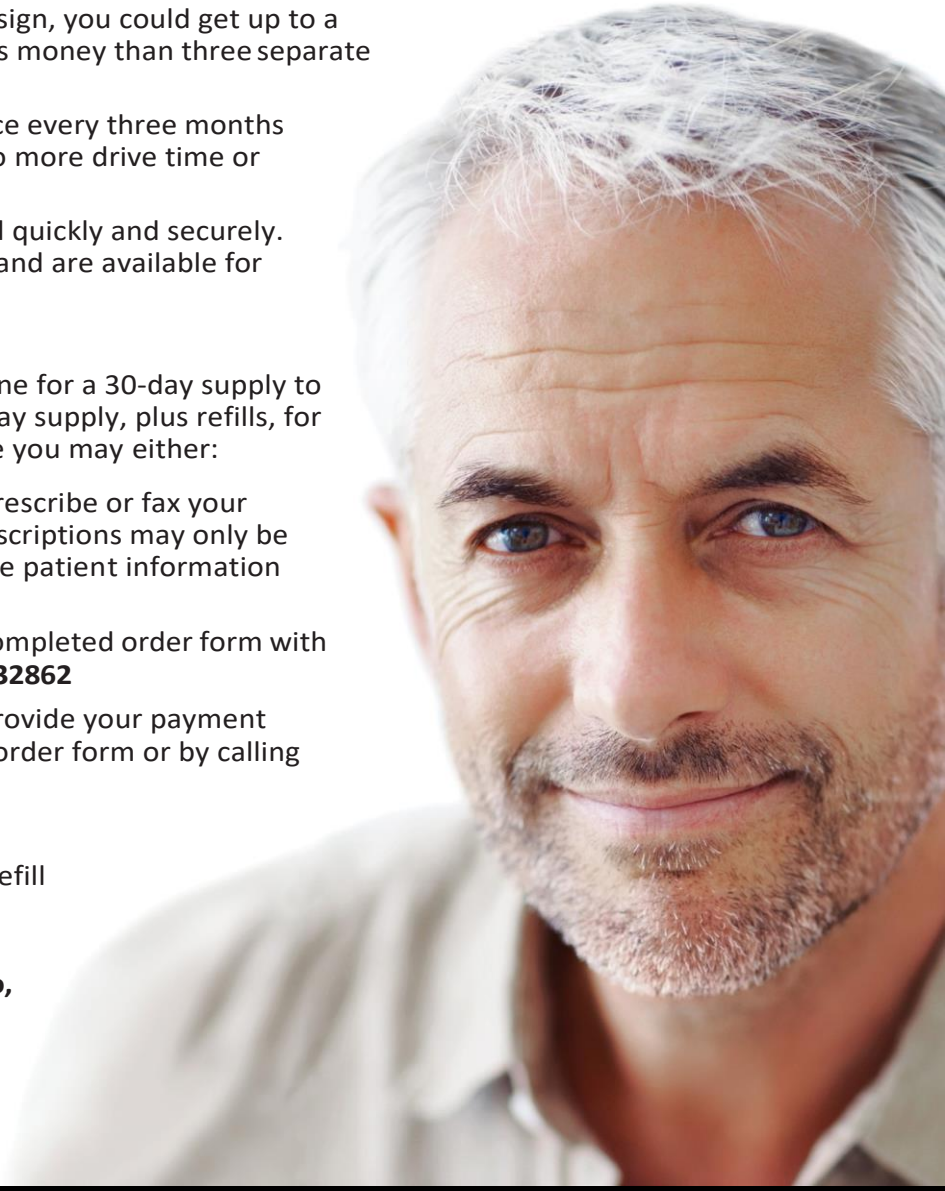
- Traditional and specialty medication details
- Disease education
- Side effect awareness

Save time and money with Magellan Rx Home

90-day supply of your medications by mail

If you take maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol you could save with Magellan Rx Home, Magellan Rx Management's mail service pharmacy.

- **Save money:** Depending on your plan design, you could get up to a 90-day supply of your medication for less money than three separate fills and standard shipping is free.
- **Save time:** Refill your medication just once every three months easily online or by phone. That means no more drive time or waiting at the pharmacy.
- **Peace of mind:** Your medication is mailed quickly and securely. Registered pharmacists check all orders and are available for help 24/7.



How to get started

Ask your doctor to write two prescriptions: one for a 30-day supply to fill at your local pharmacy and one for a 90-day supply, plus refills, for filling by mail. To get started with mail service you may either:

- **E-prescribe or Fax:** Have your doctor e-prescribe or fax your prescription to 888-282-1349. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.
- **Mail:** Mail us your 90-day prescription, completed order form with payment to **PO Box 620968 Orlando, FL 32862**

Please note: For prompt delivery, please provide your payment information by mailing in your completed order form or by calling 800-424-1771 or (TTY: 711).

Getting a refill is easy

Choose one of these simple steps to quickly refill your medication:

- **Mail:** Fill in the refill section on an order form and mail to **PO Box 620968 Orlando, FL 32862**
- **Phone:** Call us at 800-424-1771 or (TTY: 711) with your prescription number and payment information.

Frequently Asked Questions

What prescriptions do I send to Magellan Rx Home?
Magellan Rx Home fills prescriptions for maintenance medications. These are drugs that you take regularly for arthritis, asthma, diabetes, heart disease, high cholesterol or other chronic conditions.

When should I use a retail pharmacy?
You should use your local retail pharmacy for the first 30-day prescription you get from your doctor as well as prescriptions received for an acute condition like an infection.

Who can I call if I have any questions?
For questions about your pharmacy benefits plan, call the Member Services number on your member ID card. For Magellan Rx Home questions, call 800-424-1771 or (TTY: 711). Representatives can answer questions, check the status of an order or place a refill order. Pharmacists are also available to help 24/7.

Auto Refill, shipping and costs

When will I receive my medication?
After we receive your prescription, please allow 7 to 10 days for your order to arrive. To avoid delays, be sure to fill out all forms completely and include your co-payment if you know the amount due. We may need to contact your physician for additional information. Please note that orders with multiple prescriptions may be shipped separately.

Can I set my prescription up to Auto Refill?
You may set up an auto refill to receive your eligible mail service refills automatically. Call 800-424-1771 or (TTY: 711) to enroll.

Can I save money on my prescription?
Depending on your plan design, you could get a 90-day supply for less than you would pay at a retail pharmacy.

How much are the shipping charges?
Standard shipping is always free. Should you want your prescription sooner, you can choose expedited shipping for an additional charge. Please note that expedited shipping only reduces the transit time and does not impact prescription processing time.

What happens if I don't receive my order?
Making sure you have the medication you need is our top priority. If you don't receive your order within 10 days, please call us at 800-424-1771 or (TTY: 711).

About your prescriptions

Do prescriptions expire?
Most prescriptions, including refills, expire within six months to one year from the day they are written. If this happens, you'll need a new prescription from your doctor regardless of if you have refills remaining.

How are controlled substances handled?
A controlled substance, such as a narcotic, has strict guidelines and may be handled differently than a noncontrolled medication. We adhere to federal and state laws in the dispensing of all medications. We will contact you if additional information is needed to process a controlled substance prescription.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Co-payments may change on January 1 of each year. Ultimate Health Plans is an HMO with a Medicare Contract. Enrollment in Ultimate Health Plans depends on contract renewal. Discrimination is Against the Law. Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-657-4170 (TTY: 711). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. 1-888-657-4170 (TTY: 711).

Understanding Your Prescription Benefit Program

Providing you with the tools and resources to help you make better drug therapy decisions

Dedicated Partner

As your prescription benefits manager, Magellan Rx Management is dedicated to giving you the best information and resources to help you make better healthcare decisions. Our wide range of prescription benefit programs emphasize quality and cost-effective solutions that lead to better drug therapy choices.

Maximize Your Benefit

Your decisions play a key role in the effectiveness of your prescription benefit. Here are a few tips to help you maximize your benefit.

Request Generics

- Generic medications provide quality, cost-effective alternatives to brand medications and may help reduce costs to you and your plan.
- Ask your local pharmacy if they offer any low-cost generic programs. Use your prescription benefit card to process your order and receive the lower priced alternative, whether it is the pharmacy's generic program price or your copay.

Take Your Medications As Directed

- Taking medications exactly as prescribed is one of the most important things you can do to enhance your health and prevent medical complications.
- Missing doses, stopping medication early or swapping medications with other people can lead to serious problems that may negatively impact health outcomes.

Take Advantage of Over-The-Counter (OTC) Products

- Some medications that used to only be available by prescription (e.g., Claritin®, Prilosec®, and Zyrtec®) are now available over-the-counter without a prescription.
- Ask your doctor if any OTC alternatives are available to effectively treat your condition. Switching to an OTC product could save both you and your plan money.

Our Commitment

Your prescription benefit program is designed to help you and your eligible dependents obtain prescription medications conveniently and at reasonable prices. We are committed to:

- Helping you achieve the best possible health outcomes
- Promoting the use of safe, cost-effective and clinically appropriate medications
- Helping you save money and providing convenient access to your prescription medications

Online Tools at magellanrx.com

Secure online connection, protecting your confidentiality and providing useful tools and information.

- Easy-to-use tools that allow you to view, refill, renew and transfer prescriptions
- Drug formulary & lookup tools
- Trusted drug information & education
- Real-time benefit information
- View and download pharmacy claims
- Find a participating pharmacy
- Download claim, prior authorization request and mail order forms

Questions? Contact Magellan Rx Customer Service 24/7 at 1.800.424.0472 with any questions about your prescription benefit.

Magellan Rx MANAGEMENT℠

Choose Generics

Save money by choosing quality, cost-effective alternatives to brand medications

As your prescription benefits manager, Magellan Rx Management is dedicated to giving you the best information and resources to help you make better healthcare decisions. Selecting generic medications is one way to help control your health care costs without sacrificing safety and effectiveness. The following are answers to commonly asked questions about generic drugs.

What are generic drugs?

Generic drugs are important options that allow greater access to health care for all Americans. They are copies of brand-name drugs and are the same as those brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price. Generic manufacturers are able to sell their products for lower prices because they are not required to repeat the costly clinical trials of new drugs and generally do not pay for costly advertising, marketing, and promotion. In addition, multiple generic companies are often approved to market a single product; this creates competition in the market place, often resulting in lower prices.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The Food and Drug Administration (FDA) requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

Not every brand-name drug has a generic drug. When new drugs are first made they have drug patents. Most drug patents are protected for 20 years. The patent, which protects the company that made the drug first, doesn't allow anyone else to make and sell the drug. When the patent expires, other drug companies can start selling a generic version of the drug. But first, they must test the drug and the FDA must approve it.

Creating a new drug is expensive. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to market are less; therefore, generic drugs are usually less expensive than brand-name drugs. However, generic drug makers must show that their product performs in the same way as the brand-name drug.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA-approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity, and quality
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

Do generics work just as well as brand-name drugs?

A study evaluated the results of 38 published clinical trials that compared cardiovascular generic drugs to their brand-name counterparts. There was no evidence that brand-name heart drugs worked any better than generic heart drugs

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, please visit our website at magellanrx.com.

Think OTC for your Ulcer and Allergy Medications

A smarter way to think. An easier way to save.

Brand name drugs like Nexium®, Prevacid®, Prilosec,® Zyrtec®, Claritin® and Zantac® that used to only be available with a prescription are now available over-the-counter (OTC). If the OTC version is available in the same strength as the prescription drug you're currently taking, then the OTC version could provide additional savings opportunities for you. As a result, your plan has elected to cover select OTC medications at a low co-payment (after deductible, if applicable). Covered medications include non-sedating antihistamines (NSAs) and ulcer/heartburn treatments packaged as name brands, store brands or generics as long as they are prescribed by your physician and processed using your prescription benefit card at your local pharmacy.

Talk to your physician today to find out if an OTC product is right for you.

Get Started Today

To take advantage of this low co-pay OTC program, please follow these 3 easy steps once you and your doctor agree that an OTC product is right for you:

1. Ask your physician to write (or telephone in) a prescription for the specific OTC product.
   - Make sure your physician writes "OTC" on the prescription.
2. Take the prescription to your local pharmacy (not available through mail service) and ensure that your pharmacist:
   - Uses your prescription benefit card to fill the OTC prescription.
   - Fills the prescription just like any other prescription medicine, making sure to include your doctor's name and instructions on the label.
   - Charges you a low co-pay as a result of this program (after deductible, if applicable).
3. Make sure to follow your doctor's instructions for use when taking the medication.

It doesn't make any sense to pay more. Talk to your physician to find out if an OTC product is right for you and start saving today!

Examples of Covered OTC Medications

- ALAVERT
- ALLEGRA
- ALLEGRA-D
- AXID AR
- CETIRIZINE
- CIMETIDINE
- CLARITIN
- CLARITIN-D
- DIMETAPP ND
- FAMOTIDINE
- FEXOFENADINE
- FEXOFENADINE-PSEUDOEPHEDRINE
- LORATADINE
- NEXIUM 24HR OTC
- OMEPRAZOLE
- PEPCID COMPLETE
- PEPCID AC
- PREVACID 24 HR CAP
- PRILOSEC OTC
- RANITIDINE
- TAGAMET HB
- TAVIST ND
- TRIAMINIC TAB
- XYZAL OTC
- ZANTAC
- ZEGERID OTC
- ZYRTEC
- ZYRTEC-D

magellanrx.com

Magellan Rx MANAGEMENT

Welcome to Your Specialty Pharmacy

Magellan Rx Specialty, the specialty pharmacy division of Magellan Rx Management, is your specialty pharmacy delivering quality service and personalized care. We make it easy for you to quickly get your specialty medications while providing additional support to help you stay on track.

Services and programs to support your needs

When you enroll, a representative will contact you to gather important information to schedule your first delivery from Magellan Rx Pharmacy. We will stay in touch over the course of your therapy and will call with monthly refill reminders and address any questions you may have about your treatment. In addition, you also have access to many helpful services:

- **Insurance specialists** to help you get the most out of your benefits
- **Clinical programs** to help manage your condition
- **Educational materials about your condition or medication,** including at-home guides
- **Free delivery** to your home or another address within two days of ordering
- **Important supplies at no additional cost,** such as syringes and needles
- **Highly trained pharmacists and nurses** available toll-free to answer any questions
- **Online member portal** where you can request refills and learn more

Ordering your medication is fast and easy

Step 1: Have your doctor fax your prescription to us at 866-364-2673. Make sure the form includes your contact information.
If prior authorization is required, your doctor may need to take additional steps to submit your prescription.

Step 2: We will contact you to get important information and schedule your first delivery.

Step 3: Your prescription will arrive when and where you've requested.

We are here to help

If you have any questions about our services or your specialty medications, please contact us at 866-554-2673. Our standard hours are Monday through Friday from 8:00am to 10:00pm ET. Representatives are also available 24/7 for urgent requests.

Welcome to Magellan Rx Specialty

Magellan Rx MANAGEMENT

Sheppard Pratt has partnered with GoodRx to provide you with free simple, easy-to-use tools to find the right pharmacy and discounts for your prescriptions.

Sheppard Pratt powered by GoodRx

Save 20-80% on your prescriptions today!

Prescription Savings Portal

Free!

New discounts and savings opportunities are offered every day. For the latest discounts and tips, and to print out free coupons, go to: http://sheppardpratt.goodrx.com

Just type in your drug and zip code, and see how much you can save at every pharmacy near you.

KELLY provides administrative services for your benefit plans. In addition, the KELLY Total Benefits Solution (KTBSonline) provides you an integrated technology solution and resource to access your benefits information any time throughout the year. Here are some of the advantages.

Greater Accuracy: The online enrollment process guides you through the steps. The instructions are straight forward and takes the guesswork out of completing an enrollment form incorrectly.

Security: To prevent unauthorized access, maintain the integrity of the data, and ensure the appropriate use of information, KELLY uses Secure Socket Layer (SSL) technology, a protocol developed by Netscape for transmitting private documents via the Internet. SSL works by using a private key to encrypt data that's transferred over the SSL connection.

Less Paper: There is no need to complete multiple enrollment forms for multiple insurance carriers any longer. You can do it all in one easy step on KTBSonline.

Convenient 24/7 Access: Verify coverage and contributions, access key benefit information, request ID cards and more,24 hours a day, seven days a week!

Tech Support

Call the KELLY Customer Service Call Center at **1-877-290-9580**.

Representatives are standing by to assist you **Monday–Friday 8:30 a.m.–5:30 p.m.**

Login Instructions

First Time www.sphsbenefits.com Users

1. Go to https://www.sphsbenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
2. Click on the "**Register**" link located on the right-hand side of your screen.
3. When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes you will also be asked to type a randomly generated security code. Click "**Continue**".
4. Follow the directions provided on the site to complete your registration and setup your online account.

Returning www.sphsbenefits.com Users

1. Go to https://www.sphsbenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
2. Enter your Username and Password within the Secure Benefits Login section and then click "**Login"**.

Login Help and Register Features

Forgot Password

The link will provide you with either the option to enter the email address that is currently on file for your account or the option to enter your date of birth and social security number. Either option, will allow for the login information to be sent to your current email address on file.

Register

- If you do not have an email address on file, click the "Register" link. When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes you will also be asked to type a randomly generated security code. Click "**Continue**".
- You will be asked to enter your previously saved security question as you have already been identified as having a login for your account. Click "**Continue**". If at this point, you do not know your security answer, please contact Tech Support at the number listed on this form.

Benefits Information available through the

KTBSonline Employee Mobile App

The KTBSOnline mobile app provides all your essential Benefit information.

With the free KTBSonline mobile app you can:

- Access and view your current benefits
- Email a copy of your ID card to a Provider
- Email or call KELLY Call Center with questions
- Access the full KTBSonline site from your mobile phone

It's easy! Search "ktbsonline" at the iTunes App Store or Google Play to download the mobile app!

Download on the App Store

ANDROID APP ON Google play

KTBSonline
KELLY *Total Benefits Solution*® Technology

Sheppard Pratt Health System Wellness Program

The Sheppard Pratt Wellness Program for 2018-19 will continue focusing on the long-term goals of creating a culture of wellness, new activities sponsored by the wellness committee and giving employees the tools and resources they need to take charge of their own health and wellness.

Focus for the "Lead the Way" Wellness Program for this year:

- Kathy Harris, Wellness Coordinator, will continue to be the "face" of the wellness program and will promote and enhance features through the Wellness Committee
- A participant portal www.allegeantwellness.com is provided to encourage increased participation with access to a Health Risk Assessment (HRA) and personal and team challenges to focus on simple lifestyle changes. We also encourage a relationship with a Primary Care Physician (PCP), and annual physicals, tests, etc.
- Non-tobacco use discounts. Certifications for non-tobacco use status must be made through the Sheppard Pratt benefit enrollment web site for the plan year beginning July 1, 2018. Tobacco users who wish to enter a formal smoking cessation program may apply to Allegeant by contacting Kathy Harris, Wellness Coordinator at kharris@allegeant.com or 410.605.0007 x7190.

Special Focus for the plan year beginning July 1, 2018:

Health problems in the nation today include diabetes and hypertension. Lifestyle behaviors significantly contribute to the onset of these chronic diseases. Go to www.allegeantwellness.com to participate in one or more challenges to make meaningful lifestyle changes that can enhance your quality of life and decrease the risk of developing costly chronic diseases.

Earning the Wellness Program Discount

The following activities are available on the participant wellness portal www.allegeantwellness.com as requirements for the wellness discount:

- Designate a Primary Care Physician for yourself under the "Events" section of the participant portal.
- Schedule an annual wellness visit from a Primary Care Physician (PCP) of your choice. Once you have scheduled your appointment, confirm your visit under the "Events" section of the participant portal
- Complete the Health Risk Appraisal (HRA) by accessing the participant portal
- In addition, all employees are required to participate in any personal or corporate challenge available on the participant portal or any "Lead the Way" programs offered during the year.
- **By completing all of the above requirements you will earn the applicable employee discount**

For those who cannot access the participant portal a form is provided for designating a PCP and confirming the annual wellness visit. Contact the Sheppard Pratt HR for assistance in completing the HRA.

Your medical premium discount will be applied once Allegeant notifies Sheppard Pratt you have completed these requirements.

Earning ongoing Wellness Discount

Annually update your participant wellness portal, www.allegeantwellness.com with these Open Enrollment requirements:

- Schedule an annual wellness visit (between May 1, 2018 and April 30, 2019) from a Primary Care Physician (PCP) of your choice. *Confirm your scheduled visit under the "Events" section of the participant portal.*
- Update your Primary Care Physician choice (if it has changed) in the "Events" section of the participant portal.
- In addition, all employees are required to participate in any personal or corporate challenge available on the participant portal or any "Lead the Way" programs offered during the year.

Information Relating to the Primary Care Physician ("PCP") Form

The development of a relationship with your PCP should provide you with a trusted clinical resource to keep you healthy. Your selection of a Primary Care Physician should come from the following types of practice:

- Family Practitioner
- General Pediatrics
- General Internist who practices solely primary care (for example a primary who practices a subspecialty such as cardiology or hematology, etc. is considered a specialist)

If you do not have a PCP you can find one by clicking on www.carefirst.com then "Find a Doctor". When searching for an actual PCP, select the option "CareFirst – Network Leasing Member" In addition, most hospitals such as GBMC (Patient Centered Medical Home), St. Joseph, Mercy Medical, etc. have a physician locator on their respective web sites that will assist you in finding a PCP, or you may ask someone that you trust for a reference.

It is helpful that you indicate PCP selections for anyone covered by you in the Medical Plans. Should the need arise for additional help under the healthcare plans the utilization vendor, Conifer Health Solutions, may contact the PCP for coordination of care under your benefits.
You may change your PCP at any time.

SIGN ONTO THE ALLEGEANT WELLNESS PORTAL

Go to www.AllegeantWellness.com

Company ID: SPHS

Employee ID: 6 Digit Employee ID Number

SHEPPARD PRATT HEALTH SYSTEM MEDICAL PLAN TOBACCO POLICY

SPHS offers a Discount in Medical Plan Contributions for Non Tobacco Users

SPHS is offering a premium discount for non tobacco users as part of a program to encourage employees to improve or maintain their own health by avoiding or ceasing the use of tobacco products. According to the Centers of Disease Control:

- Annually smoking costs more than $193 billion ($97 billion in lost productivity and $96 billion in health care expenditures, or an average of $4,260 per adult smoker (2004)
- Cigarette smoking is the leading preventable cause of death in the United States
- Among adult smokers, 70% report that they want to quit completely, and more than 40% try to quit each year.
- The list of diseases caused by smoking includes bladder, esophageal, lung, oral and throat cancers, chronic lung diseases, coronary heart and cardiovascular diseases

This policy is also consistent with our Smoke Free Campus Policy.

DISCOUNTED COSTS FOR TOBACCO-FREE EMPLOYEES
Under this policy, employees who are tobacco-free are eligible to receive discounts on their employee contributions for individual and dependant coverage.

WHAT IS A TOBACCO USER?
If you have smoked one (1) cigarette (including an e-cigarette), one (1) cigar or used chewing tobacco one time in the past six (6) months you are considered a tobacco user.

Whether you are eligible for the tobacco-free discount is determined each year on a calendar year basis. If you certify that you have been tobacco-free for six consecutive months as of July 1 of each open enrollment, and agree to remain tobacco-free during the next plan year, you may take advantage of the tobacco-free discounted rates in the next plan year by making a certification during the online open enrollment. This is the only time during the plan year you can make this certification. If you fail to provide this certification buy July 1 each year, you will not qualify for the discounted rates for the following year (unless you qualify for the lower rates under a "Reasonable Alternative" standard, as described below).

WHAT IF I QUIT SMOKING?
If you quit smoking at a time when you do not qualify for the discounted rates, you will continue to pay the higher rates for the rest of the year, but you may qualify for the discounted rates for the next calendar year, if you can certify at that year's open enrollment that you have been tobacco-free for six consecutive months (or if you qualify for the lower rates under a "Reasonable Alternative" standard, as described below).

WHAT IF I BEGIN USING TOBACCO AFTER I'VE CERTIFIED I'M A NON-USER?
If you smoke one (1) cigarette (including an e-cigarette), one (1) cigar or use chewing tobacco after you've certified yourself as a non-tobacco user, it is your obligation notify Human Resources to change your election to "Tobacco User" if you do not qualify as tobacco-free at that time. In that case, you will no longer qualify for the tobacco-free discount for the next calendar year (unless you qualify for the tobacco-free discount for the discounted rates under a "Reasonable Alternative" standard, as described below).

NEW HIRES
All new hires must certify non-smoking or non-user status at enrollment and will be subject to the same rules as described.

DO YOU WANT HELP?
SPHS's medical and prescription drug programs include resources to help you quit using tobacco products. Our prescription drug plan covers various smoking cessation products. Our Wellness Coordinator provides assistance and literature for this program.

REASONABLE ALTERNATIVE
If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), contact Human Resources and we will make available a reasonable alternative standard for you to avoid the higher premium that applies to tobacco users. We may require that you provide documentation from a physician regarding the health factor or medical condition that prevents you from stopping your use of tobacco.
If you qualify for a reasonable alternative method, the reasonable alternative may include, for example, participation in smoking cessation programs, use of nicotine patches, nicotine gum or other physician – recommended alternatives. If you are paying the lower premium based on your participation in a reasonable alternative program, we reserve the right to require regular evidence of continuing participation, as well as signed affidavits regarding your participation or documentation from your physician regarding any health factor or medical condition that would qualify you for the reasonable alternative.

HONOR SYSTEM
SPHS's Medical Plan Tobacco Policy is based on the honor system. Employees who qualify for the tobacco-free discount based on false information regarding their use of tobacco or their participation in a reasonable alternative program will be subject to forfeiture of their discount.

myAllegeant – an online portal where you and your dependents can have easy access to self-service tools that allow you to take an active role in your health plan's benefits.

To register, go to www.myallegeant.com, click on "*Proceed to our sign up process*", and have your ID card ready.

Features:

- Eligibility – effective dates, demographic information, summary of benefits and coverage.
- Claims – summary of all claims, claims status, paid date, explanation of benefits (EOB).
- Out-of-pocket and deductible amounts – see where you stand year-to-date.
- Secure messaging – send questions to customer service about claims, eligibility, address changes, or request a new ID card.
- ID card – view or print a temporary ID card.
- Notifications – an email notification is sent to you when there is a secure message from customer service.
- Announcements and information – new features or processes at Allegeant, FAQs, plan information.
- Links to other tools – find a network provider, access the wellness portal, view prescription claims, manage your FSA/HSA/HRA.
- eEOBs – go paperless and sign up for eEOBs
    - When an EOB/claim is ready to be viewed, you will get an email notification alerting you that your EOB is ready to be viewed on myAllegeant.

If you need help registering, click on "*Sign Up Instructions*" underneath the login field. For continued assistance or if have a question about eligibility or claims, please contact Allegeant Customer Service at 1-800-553-8635.

Sheppard Pratt Health System

Dental Benefits Plan Comparison

(Effective July 1, 2018 – June 30, 2019)

Plan Characteristics	DHMO	PPO	
In-Network Benefits	Yes	Yes	
Required to Use An Assigned Provider	Yes	No	
Out of Network Benefits Available	No	Yes	
Claim Required	No	Yes* ***(For Out-of-Network Services Only)***	
Balance Billing for Covered Services	No	Yes* ***(For Out-of-Network Services Only)***	
Specialty Referral Required	Yes	No	
Orthodontia Benefits Available	Yes ***(Any Age)***	Yes ***(To Age 19)***	
Orthodontia Maximum (Lifetime)	None	$1,500.00	
Annual Benefit Maximum (per person)	None	$1,500.00	
Annual Deductible (per person)**	None	$50.00 (In-Network)	$100.00 (Out-Of-Network)
Maximum Deductible (per family)**	None	$100.00 (In-Network)	$200.00 (Out-Of-Network)

**** Applies when using any non-participating provider under this plan.***
*****Deductibles apply to Classes 2 and 3 In-Network, and Class 1, 2 and 3 Out-of-Network.***
Eligible dependents are covered up to age 26 regardless of student status

Network Notes:

- **DHMO** – **IN-NETWORK ONLY. *"Concordia Plus"* network.** Network is regional in scope. Providers may close to new plan participants/patients. You may choose to be assigned to open providers in Maryland or any bordering state.

- **PPO** – **IN and OUT-OF-NETWORK COVERAGE. *"Advantage Plus" network.*** Participating providers may close to new patients whenever they choose. **It is recommended that you check with the provider office to make sure they are accepting new patients under the PPO plan if you intend to move to this coverage based on a specific provider's participation.** In-network providers may not balance-bill.

- Find network providers on-line at **www.unitedconcordia.com**
  or by calling **Customer Service** at **1-800-332-0366**

All services listed on this benefit summary are subject to the contract, Schedules of Benefits, and the Exclusions and Limitations.

UNITED CONCORDIA
Insuring America's Dental Health

UNITED CONCORDIA® DENTAL

Dental Benefits Summary for Sheppard Pratt

Network: Advantage *Plus*

Benefit Category[1]	CONCORDIA PREFERRED PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative[3] (Fillings)	80%	80%
Simple Extractions		
Space Maintainers		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Bridges, Dentures)		
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	50%	50%
Included Plan Features		
Pregnancy Benefit	Covers 1 additional cleaning during pregnancy.	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Annual Program Deductible (per person/per family) (July 1- June 30)	$50/$100 Excludes Class I & Orthodontics	$100/$200 Excludes Class I & Orthodontics
Annual Program Maximum (per person) (July 1- June 30)	$1,500 Excludes Class I & Orthodontics	
Lifetime Orthodontic Maximum (per person)	$1,500	
Reimbursement	**Advantage *Plus***	**85th Percentile**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Unmarried dependent children covered to age 26.
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitations apply.
3. Includes coverage for composite (tooth colored) resin fillings when performed on posterior teeth.

UnitedConcordia.com • 1-800-332-0366

(Eff 7/1/2018)

IMPORTANT INFORMATION ABOUT YOUR PLAN

- This schedule of benefits provides a listing of procedures covered by your plan. For procedures that require a copayment, the amount to be paid is shown in the column titled "Member Pays $." You pay these copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive covered services. Your PDO will perform the below procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered, except as described in the Certificate of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- For a complete description of your plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- If you have any questions about your United Concordia dental plan, please call our Customer Service Department toll-free at 1-866-357-3304 or access our website at www.UnitedConcordia.com.

ADA Code	ADA Description	Member Pays $
	CLINICAL ORAL EVALUATIONS	
D0120	Periodic Oral Evaluation - Established Patient	5
D0140	Limited Oral Evaluation - Problem Focused	5
D0145	Oral Evaluation For A Patient Under 3 Years Of Age And Counseling With Primary Caregiver	5
D0150	Comprehensive Oral Evaluation - New Or Established Patient	5
D0170	Re-Evaluation-Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	5
D0171	Re-Evaluation - Post-Operative Office Visit	0
D0180	Comprehensive Periodontal Evaluation	5
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0210	Intraoral - Complete Series Of Radiographic Images	0
D0220	Intraoral- Periapical First Radiographic Image	0
D0230	Intraoral- Periapical Each Additional Radiographic Image	0
D0240	Intraoral - Occlusal Radiographic Image	0
D0270	Bitewing - Single Radiographic Image	0
D0272	Bitewings - Two Radiographic Images	0
D0273	Bitewings - Three Radiographic Images	0
D0274	Bitewings - Four Radiographic Images	0
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0
D0330	Panoramic Radiographic Image	0
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement And Analysis	0
	TESTS AND EXAMINATIONS	
D0460	Pulp Vitality Tests	0
D0470	Diagnostic Casts	0
	ORAL PATHOLOGY LABORATORY	
D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	0
D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	0
D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis, Adult	0
D1120	Prophylaxis, Child	0
	TOPICAL FLUORIDE TREATMENT (office procedure)	
D1206	Topical Application Of Fluoride Varnish	0
D1208	Topical Application Of Flouride - Excluding Varnish	0
	OTHER PREVENTIVE SERVICES	
D1330	Oral Hygiene Instruction	0
D1351	Sealant - Per Tooth	0
D1353	Sealant Repair - Per Tooth	0
D1354	Interim Caries Arresting Medicament Application - Per Tooth	15
	SPACE MAINTENANCE (passive appliances)	
D1510	Space Maintainer - Fixed, Unilateral (Tooth Numbers Or Tooth Area Required)	69
D1515	Space Maintainer - Fixed, Bilateral	108
D1520	Space Maintainer - Removable, Unilateral	86
D1525	Space Maintainer - Removable, Bilateral	122
D1550	Re-Cement Or Re-Bond Space Maintainer	12
D1555	Removal Of Fixed Space Maintainer	26
D1575	Distal shoe space maintainers - fixed - unilateral	69
	AMALGAM RESTORATIONS (including polishing)	
D2140	Amalgam - One Surface, Primary Or Permanent	9
D2150	Amalgam - Two Surfaces, Primary Or Permanent	12
D2160	Amalgam - Three Surfaces, Primary Or Permanent	15
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	17

ADA Code	ADA Description	Member Pays $	
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-Based Composite - One Surface, Anterior	20	
D2331	Resin-Based Composite - Two Surfaces, Anterior	30	
D2332	Resin-Based Composite - Three Surfaces, Anterior	35	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	42	
D2391	Resin-Based Composite - One Surface, Posterior	45	
D2392	Resin-Based Composite - Two Surfaces, Posterior	75	
D2393	Resin-Based Composite - Three Surfaces, Posterior	88	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	100	
	INLAY/ONLAY RESTORATIONS		
D2510	Inlay - Metallic - One Surface	222	◆
D2520	Inlay - Metallic - Two Surfaces	248	◆
D2530	Inlay - Metallic - Three Or More Surfaces	307	◆
D2542	Onlay - Metallic-Two Surfaces	282	◆
D2543	Onlay - Metallic - Three Surfaces	330	◆
D2544	Onlay - Metallic - Four Or More Surfaces	363	◆
	CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown-Resin-Based Composite (Indirect)	119	
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	119	
D2740	Crown, Porcelain/Ceramic	450	
D2750	Crown, Porcelain Fused To High Noble Metal	420	◆
D2751	Crown-Porcelain Fused To Predominantly Base Metal	400	
D2752	Crown, Porcelain Fused To Noble Metal	410	◆
D2790	Crown, Full Cast High Noble Metal	420	◆
D2791	Crown - Full Cast Predominantly Base Metal	400	
D2792	Crown, Full Cast Noble Metal	410	◆
D2794	Crown-Titanium	400	
D2799	Provisional Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	97	
	OTHER RESTORATIVE SERVICES		
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	23	
D2915	Re-Cement Or Rebond Indirectly Fabricated Or Prefabricated Post And Core	25	
D2920	Re-Cement Or Re-Bond Crown	25	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	81	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	97	
D2949	Restorative Foundation For An Indirect Restoration	0	
D2950	Core Buildup Including Any Pins When Required	75	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	13	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	120	
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	62	
D2954	Prefabricated Post And Core In Addition To Crown	85	

ADA Code	ADA Description	Member Pays $
	OTHER RESTORATIVE SERVICES	
D2957	Each Additional Prefabricated Post - Same Tooth	44
D2971	Additional Procedures To Construct New Crown Under Existing Partial Denture Framework	25
	PULP CAPPING	
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0
	PULPOTOMY	
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	52
D3221	Pulpal Debridement, Primary And Permanent Teeth	26
D3222	Partial Pulpotomy For Apexogenesis-Permanent Tooth With Incomplete Root Development	52
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal Therapy (Resorbable Filling)-Anterior, Primary Tooth (Excluding Final Restoration)	104
D3240	Pulpal Therapy (Resorbable Filling)-Posterior, Primary Tooth (Excluding Final Restoration)	123
	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	200
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	250
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	335
	ENDODONTIC RETREATMENT	
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	295
D3347	Retreatment Or Previous Root Canal Therapy - Premolar	340
D3348	Retreatment Of Previous Root Canal Therapy - Molar	428
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - Anterior	220
D3421	Apicoectomy - Premolar (First Root)	240
D3425	Apicoectomy - Molar (First Root)	240
D3426	Apicoectomy (Each Additional Root)	97
D3427	Periradicular Surgery Without Apicoectomy	240
D3430	Retrograde Filling - Per Root	0
D3450	Root Amputation - Per Root	143
	OTHER ENDODONTIC PROCEDURES	
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	130
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	0
	SURGICAL SERVICES (including usual postoperative care)	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	207
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	65
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0

ADA Code	ADA Description	Member Pays $
	SURGICAL SERVICES (including usual postoperative care)	
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	188
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	75
D4249	Clinical Crown Lengthening-Hard Tissue	259
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	360
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	144
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	130
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	120
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	225
	NON-SURGICAL PERIODONTAL SERVICES	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	75
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	19
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth, After Oral Evaluation	58
D4355	Full Mouth Debridement To Enable a Comprehensive Oral Evaluation And Diagnosis on a Subsequent Visit	45
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	100
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal Maintenance	58
D4921	Gingival Irrigation - Per Quadrant	25
	COMPLETE DENTURES (including routine post delivery care)	
D5110	Complete Denture - Maxillary	375
D5120	Complete Denture - Mandibular	375
D5130	Immediate Denture - Maxillary	400
D5140	Immediate Denture - Mandibular	400
	PARTIAL DENTURES (including routine post-delivery care)	
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	300
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	300
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	425
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rest And Teeth)	425
D5221	Immediate Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	300
D5222	Immediate Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	300
D5223	Immediate Maxillary Partial Denture - Case Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	425
D5224	Immediate Mandibular Partial Denture - Case Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	425
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	489
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	489
D5281	Removable Unilateral Partial Denture-One Piece Cast Metal (Including Clasps	195
	ADJUSTMENTS TO DENTURES	
D5410	Adjust Complete Denture - Maxillary	24
D5411	Adjust Complete Denture - Mandibular	24
D5421	Adjust Partial Denture - Maxillary	24
D5422	Adjust Partial Denture - Mandibular	24
	REPAIRS TO COMPLETE DENTURES	
D5511	Repair Broken Complete Denture Base, Mandibular	60
D5512	Repair Broken Complete Denture Base, Maxillary	60
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	50
	REPAIRS TO PARTIAL DENTURES	
D5611	Repair Resin Partial Denture Base, Mandibular	60
D5612	Repair Resin Partial Denture Base, Maxillary	60
D5621	Repair Cast Partial Framework, Mandibular	75
D5622	Repair Cast Partial Framework, Maxillary	75
D5630	Repair Or Replace Broken Clasp - Per Tooth	75
D5640	Replace Broken Teeth-Per Tooth	60
D5650	Add Tooth To Existing Partial Denture	75
D5660	Add Clasp To Existing Partial Denture - Per Tooth	75
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	276
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	276
	DENTURE REBASE PROCEDURES	
D5710	Rebase Complete Maxillary Denture	155
D5711	Rebase Complete Mandibular Denture	155
D5720	Rebase Maxillary Partial Denture	140
D5721	Rebase Mandibular Partial Denture	140
	DENTURE RELINE PROCEDURES	
D5730	Reline Complete Maxillary Denture (Chairside)	90
D5731	Reline Complete Mandibular Denture (Chairside)	90
D5740	Reline Maxillary Partial Denture (Chairside)	80
D5741	Reline Mandibular Partial Denture (Chairside)	80
D5750	Reline Complete Maxillary Denture (Laboratory)	130
D5751	Reline Complete Mandibular Denture (Laboratory)	130

ADA Code	ADA Description	Member Pays $	
	DENTURE RELINE PROCEDURES		
D5760	Reline Maxillary Partial Denture (Laboratory)	130	
D5761	Reline Mandibular Partial Denture (Laboratory)	130	
	OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Maxillary	55	
D5851	Tissue Conditioning, Mandibular	55	
D5863	Overdenture - Complete Maxillary	375	
D5864	Overdenture - Partial Maxillary	425	
D5865	Overdenture - Complete Mandibular	375	
D5866	Overdenture - Partial Mandibular	425	
	FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - Indirect Resin Based Composite	475	
D6210	Pontic-Cast High Noble Metal	420	◆
D6211	Pontic-Cast Predominatly Base Metal	400	
D6212	Pontic-Cast Noble Metal	410	◆
D6214	Pontic - Titanium	400	
D6240	Pontic-Porcelain Fused To High Noble Metal	420	◆
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	400	
D6242	Pontic-Porcelain Fused To Noble Metal	410	◆
D6245	Pontic - Procelain/Ceramic	475	
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Retainer Crown - Indirect Resin Based Composite	475	
D6740	Retainer Crown - Porcelain/Ceramic	475	
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	420	◆
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	400	
D6752	Retainer Crown, Porcelain Fused To Noble Metal	410	◆
D6790	Retainer Crown, Full Cast High Noble Metal	420	◆
D6791	Retainer Crown, Full Cast Predominantly Base Metal	400	
D6792	Retainer Crown, Full Cast Noble Metal	410	◆
D6794	Retainer Crown - Titanium	400	
	OTHER FIXED PARTIAL DENTURE SERVICES		
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	42	
	EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7111	Extraction, Coronal Remnants - Primary Tooth	14	
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	35	
	SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	60	
D7220	Removal Of Impacted Tooth - Soft Tissue	78	
D7230	Removal Of Impacted Tooth - Partially Bony	100	
D7240	Removal Of Impacted Tooth - Completely Bony	130	
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	151	
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	76	

ADA Code	ADA Description	Member Pays $
	SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7251	Coronectomy-Intentional Partial Tooth Removal	130
	OTHER SURGICAL PROCEDURES	
D7280	Exposure Of An Unerupted Tooth	121
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	30
D7288	Brush Biopsy - Transepithelial Sample Collection	45
	ALVEOLOPLASTY (surgical preparation of ridge for dentures)	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	60
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	76
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	30
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	81
	OTHER REPAIR PROCEDURES	
D7960	Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure Not Incidental To Another Procedure	108
D7963	Frenuloplasty	54
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited Orthodontic Treatment Of Primary Dentition	750
D8020	Limited Orthodontic Treatment Of Transitional Dentition	750
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	750
D8040	Limited Orthodontic Treatment Of The Adult Dentition	750
	INTERCEPTIVE ORTHODONTIC TREATMENT	
D8050	Interceptive Orthodontic Treatment Of Primary Dentition	900
D8060	Interceptive Orthodontic Treatment Of Transitional Dentition	900
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	2900
D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	2900
D8090	Comprehensive Orthodontic Treatment Of Adult Dentition	2900
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable Appliance Therapy For Control Of Harmful Habits	375
D8220	Fixed Appliance Therapy For Control Of Harmful Habits	375
	OTHER ORTHODONTIC SERVICES	
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	275
✙	Orthodontic Records Fee	250
	UNCLASSIFIED TREATMENT	

ADA Code	ADA Description	Member Pays $
	UNCLASSIFIED TREATMENT	
D9110	Palliative (Emergency) Treatment Of Dental Pain, Minor Procedures	26
	PROFESSIONAL CONSULTATION	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	43
D9311	Consultation With A Medical Health Care Professional	0
	PROFESSIONAL VISITS	
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
D9440	Office Visit After Regularly Scheduled Hours	54
	MISCELLANEOUS SERVICES	
D9932	Cleaning And Inspection Of Removable Complete Denture, Maxillary	0
D9933	Cleaning And Inspection Of Removable Complete Denture, Mandibular	0
D9934	Cleaning And Inspection Of Removable Partial Denture, Maxillary	0
D9935	Cleaning And Inspection Of Removable Partial Denture, Mandibular	0
D9986	Missed Appointment	11
D9987	Cancelled appointment	11
D9991	Dental Case Management - Addressing Appointment Compliance Barriers	0
D9992	Dental Case Management - Care Coordination	0
D9993	Dental Case Management - Motivational Interviewing	0
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	0
D9995	Teledentistry - Synchronous; Real-Time Encounter	0
D9996	Teledentistry - Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	0
	FOOTNOTES	
◆	Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.	
✙	Please Report Under Code D8999 "Unspecified Orthodontic Procedure, By Report." Records Include All Diagnostic Procedures, Such As Cephalometric Films, Full Mouth X-Rays, Models, And Treatment Plans.	

DAVIS VISION: BENEFITS YOU CAN SEE

Eye health plays a big role in full-body wellness. That's why we've partnered with Davis Vision to make eye care more affordable.

Thanks to this partnership, United Concordia members can get discounted eye exams, lenses, frames and other eyewear options at more than 35,000 locations nationwide.

Benefits Include:

- Industry's only FREE breakage warranty (12 months)
- EPIC Hearing Savings plan—Provides members access to hearing care professionals and savings up to 60% off retail.
- Laser Vision Correction—Save up to 25% off usual and customary fees or 5% off a center's advertised special, through our network of preeminent physicians affiliated with Eye Centers of Excellence.

How it Works

Just visit a participating vision provider, then present your discount card with control code to receive special pricing. (Complete and cut out the card on this sheet). If your current health plan already includes vision benefits, visit a network provider for the exam, then use a Davis Vision contracted provider for eyewear purchases. (Please verify that the eyewear provider accepts outside prescriptions prior to the appointment.)

Find a Provider and Access Benefits Information

Online
- Visit **DavisVision.com** and select **Member**. Enter **Client Code 7602**.
- Here you can find a provider, review benefits, access forms, buy replacement contacts and more

By Phone
- Call **1-877-923-2847** and enter **Client Code 7602** when prompted

DAVISVISION®
SEE LIFE

This card entitles the bearer and family to special discounted pricing

Name _____

Group United Concordia

Client Code 7602

Signature _____

Benefits you can see.

Davis Vision Discount Schedule	Member Cost
Eye Examination	
Complete Examination	15% off Usual & Customary
Contact Lens Examination	15% off Usual & Customary
Frame	
Frame—up to $70.00 retail	$40.00
Frame—over $70.00 retail	$40.00 plus 10% off the amount over $70.00
Spectacle Lenses	
Single Vision Lenses	$35.00
Bifocal Lenses	$55.00
Trifocal Lenses	$65.00
Lenticular Lenses	$110.00
Options (Add to Spectacle Lenses Prices)	
Standard Progressive Lenses	$75.00
Premium Progressive Lenses	$125.00
Polarized	$75.00
High Index Lenses	$55.00
Glass Lenses	$18.00
Polycarbonate Lenses	$30.00
Blended Invisible Bifocals	$20.00
Intermediate Vision Lenses	$30.00
Scratch Resistant Coating	$15.00
Anti-Reflective Treatment	$45.00
Ultraviolet Coating	$15.00
Solid Tint	$10.00
Gradient Tint	$12.00
PGX Lenses	$35.00
Plastic Photosensitive Lenses	$65.00
Contact Lenses	
Conventional	20% off Usual & Customary
Disposable/Planned Replacement	10% off Usual & Customary
Other Products	
Non-Prescription Sunglasses	20% off Usual & Customary
Other Ancillary Products/Solutions	10% off Usual & Customary
Laser Vision Correction	Up to 25% off Usual & Customary

Note: Any special lens designs, materials, powers and frames may require additional payment.

GET THE CARE YOU NEED FOR YOUR HEARING

Hearing Savings Plans Available for Davis Vision Members

Davis Vision members are eligible for a hearing savings plan through EPIC Hearing Healthcare. EPIC's hearing savings plan provides Davis Vision members and their families' access to the largest network of hearing care professionals, including Ear, Nose & Throat Physicians, Audiologists and Hearing Instrument Specialists, with over 5,000 locations in all 50 states.

Benefits Include:

- Fixed pricing, reduced up to 60% below retail
- Lowest entry level pricing starting at $495 for name brand, digital hearing aids
- Managed access to credentialed audiologists and ENTs
- 45-Day money back trial period
- One-year supply of batteries per device purchased*
- Extended 3-year repair loss & damage warranties*

**Entry level hearing devises come with a one year warranty; batteries not included*

Member Savings Breakdown:

TECHNOLOGY LEVELS	AVERAGE PRICE	EPIC HSP PRICE	MEMBER SAVINGS
Entry	$1,400	$495	**$905**
Essential	$1,650	$999 / $1,199	**$550**
Standard	$2,250	$1,299 / $1,499	**$850**
Advanced	$2,700	$1,899 / $2,099	**$700**
Premium	$3,500	$2,399 / $2,499	**$1,050**

Register Now:

To sign up for your EPIC hearing savings plan, visit **epichearing.com/registration** or call **(844) 246-0544**. You will need to identify that you are a Davis Vision plan member. An EPIC hearing counselor can help you to locate participating providers in your area, coordinate a referral for care, and provide a summary plan description with a member benefit card.

EEM-0124-1117

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

United Concordia policies cover only dental benefits with an optional vision rider available. United Concordia's Group Policy begins on the agreed effective date and renews subject to the terms of the Group Policy. Either the employer/group or United Concordia may elect not to renew the Group Policy by providing written notice to the other party at least 31 days prior to renewal. United Concordia may terminate the Group Policy with 31 days written notice if the employer/group fails to pay premium. United Concordia may adjust rates or benefits or terminate the Policy on any premium due date with 31 days advance notice if the minimum participation requirements are not achieved or the nature of the risk changes significantly. Employees/members may be subject to open enrollment periods, late enrollment or voluntary disenrollment restrictions, or continuous enrollment to advance benefit level as required by the Group Policy terms. Employees/members must also meet their employer's or group's eligibility requirements or waiting period for insurance. The amount of benefits and cost depend upon the plan selected. Policy Number: 9802 (11/07) or 9802L (11/07). Underwritten by United Concordia Insurance Company. UCVision benefits are administered by Davis Vision, Inc. Vision discounts are not insurance and are available only from Davis Vision contracted providers. Hearing savings plan and discounts are also not insurance and are available only from EPIC Hearing contracted providers. *Note that UCVision riders are not permitted for groups sitused in AL. They also are not available for sale with DHMO products. Vision-only advertisements are not intended for distribution in AL or for use when only DHMO products are offered.

Get access to the best in eye care and eyewear with SHEPPARD PRATT HEALTH SYSTEM and VSP® Vision Care.

VSP® Vision care for life

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com**®, VSP's preferred online eyewear store.

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

SHEPPARD PRATT HEALTH SYSTEM and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Signature

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$15	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every 12 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

AVOID THE BLUE LIGHT BLUES

All that blue light exposure from digital devices can lead to eye strain and fatigue. And with **2 out of 3 people** in the U.S. experiencing digital eye strain,[1] your employees' eyes are probably working overtime.

SCREEN TIME IS TAKING OVER That's bad for productivity:

88% MILLENNIALS | **83%** GENEXERS | **76%** BOOMERS

Spend over two hours a day on a digital device[2]

FIGHT FOR YOUR SIGHT How to reduce blue light exposure:

20 | 20 | 20
Every 20 Minutes,
Look 20 Feet Away
For 20 Seconds

Shut down
TWO HOURS
before bed

Minimize effects with
BLUE LIGHT-FILTERING
eyewear

VSP® HAS YOUR BACK

VSP members can already save big on anti-reflective (AR) coatings, our secret weapon in the battle against blue light. But you can up the savings even more by:

☑ INCLUDING
The VSP Computer Vision Plan℠ with covered AR

☑ ADDING
AR coverage to your plan

☑ GIVING
the choice to upgrade to a premium plan with covered AR

Go easy on your employees' eyes...and wallets.
Include a covered AR coating in your VSP plan

1. 2017 Digital Eye Strain Report, The Vision Council. **2**. Vision Council, Hindsight is 20/20.

More Than $2,500 in Savings with VSP Exclusive Member Extras

LENSES AND FRAMES

EXTRA $20 TO SPEND

UP TO 40% OFF LENS ENHANCEMENTS

eyeconic

Eyezen+

sunsync

techshield Blue

Transitions

unity

ZEISS

CONTACTS

BAUSCH+LOMB
See better. Live better.

CooperVision

LASIK

The LASIK Vision INSTITUTE

NVISION EYE CENTERS

TLC Laser Eye Centers

HEARING AIDS AND FINANCING

TruHearing

CareCredit

VSP SIMPLE VALUES

VSP® Simple Values, helps you live a balanced life by providing discounts on prescription drugs, lab work, telemedicine, and diabetic supplies, as well as travel, theme park passes, movie tickets, rental cars, plus much more.

PREMIER PROGRAM

Look for this symbol in **Find a Doctor** at **vsp.com** for locations offering even more great savings.

Check out offers from these brands at **vsp.com/specialoffers.**

VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain health care groups for hearing aid sales and services; TruHearing provides fitting, programming and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those health care providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California. 12162 VCCM

THE ULTIMATE PROVIDER PLAYLIST

The right song can set the mood, and the right vision provider can set the tone for a great eye care experience. With VSP®, your employees have the freedom to choose a provider they can really groove with.

MORE CHOICES. MORE FREEDOM.

VSP NETWORK PROVIDERS

84K ACCESS POINTS

VSP® Vision Care

When it comes to choices, VSP has your employees and their eyes covered with a huge network of independent doctors, popular retailers, and an online option.

Independent Doctors

91% offer early morning, evening, and weekend appointments.

24-hour access to emergency care.

Eye Health Management Program®.

VSP Premier Program gives members the most out of their eye care experience at one location.

VSP® PREMIER PROGRAM

Retail Chains

For employees who prefer their favorite retailer, our network includes tons of participating retail chains, including:

COHEN'S Fashion Optical

COSTCO OPTICAL

myeyedr. trusted doctors, defining vision care.

Walmart

PEARLE VISION

Visionworks

Buy Online, Anytime!

Want even more options? You got it! Your employees can shop the latest designer glasses and name brand contacts online at Eyeconic.com® with their VSP benefits.

eyeconic®

Effortless Out-of-network Shopping.

Saying, "I have VSP," is all it takes to shop out-of-network. We'll do the rest!

Enjoy the sweet song of employee satisfaction with true freedom of choice from VSP.

Access **vsp.com** from Your Smartphone

vsp® Vision care for life

Now you can manage your eyecare needs at any time, and from anywhere.

- Find a doctor by name or location, and get directions to your appointment.
- Access personal benefit information, including your Member Vision Card.
- View Exclusive Member Extras, like rebates, special offers, and promotions.
- Get eyecare information on a variety of topics to maintain optimal eye health.

Scan to access **vsp.com.**

JOB#13374CM 6/13

VSP® Individual Plans Have You Covered

If you're retiring, ineligible, or no longer have access to vision care through work, we can help. Enroll directly in an annual VSP Individual Vision Plan* with 12 monthly installments as low as $17 a month and receive:

Lowest Out-of-pocket Cost.
More than $200 in annual savings, plus up to 60% savings on digital hearing aids through TruHearing®.[1]

Comprehensive Coverage.
Choose a vision plan, lens enhancements (like no-line bifocals), and featured frames that fit your budget.

Trusted Doctor.
Keep your VSP network doctor (or choose from one of 33,000 network doctors) who provide a WellVision Exam® to check your eye health annually.

Superior, Personalized Service.
Count on the experience of VSP representatives to guide you through enrollment and all your vision service needs.

"When I retired, I lost my employer-sponsored vision insurance and discovered VSP... My optometrist said this was the best plan of the ones they honor. I have been on this plan for four years and have been extremely pleased with the service, the value, and the choices."

~Stephen C. Lincolnton, North Carolina

vsp individual vision plans

ENROLLMENT IS EASY, OPEN YEAR-ROUND

VISIT:
individualvision.com/east
OR CALL:
To continue with VSP
844.608.4746
If you are new to VSP
844.508.4746
Referral code: east

SEE WHY WE'RE CONSUMERS' #1 CHOICE IN VISION CARE[2]

*This vision plan has exclusions and limitations. For cost and complete details of coverage, contact VSP.

1. Offer not available in the states of Washington or California.
2. 2017 National Vision Plan Member Research.

LIFE INSURANCE

Sheppard Pratt offers basic group life insurance and the opportunity to purchase additional life insurance and other coverage at competitive group rates through MetLife as described below.

- **BASIC (Employer Paid) GROUP LIFE INSURANCE**
  Sheppard Pratt provides you with term life insurance in the amount of 1 (one) times your annual salary to a maximum of $500,000.

- **SUPPLEMENTAL LIFE**
  In addition to the basic life, you may purchase between ½ times your annual salary up to 1 times your annual salary of Supplemental Life insurance for yourself. The maximum coverage for Supplemental Life is $1,000,000. You must have an approved Statement of Health to enroll in Supplemental Life or to increase your Supplemental Life coverage up to the lesser of $300,000 or 1 times your annual salary.

- **SUPPLEMENTAL LIFE INSURANCE FOR YOUR SPOUSE**
  You may purchase Supplemental Life insurance for your spouse in the amount of $25,000 (not to exceed the amount of your Employee Basic Life plus Employee Supplemental Life amount).

- **SUPPLEMENTAL LIFE INSURANCE FOR YOUR ELIGIBLE DEPENDENT CHILDREN**
  You may purchase Supplemental Life insurance for your eligible dependent children in the amount of $10,000 ($1,000 for children 6 months old or less).

EVIDENCE OF INSURABILITY
If you apply for Supplemental Life coverage and you have been hospitalized within 90 days of enrollment, a full Statement of Health must be completed. You must have an approved Statement of Health to enroll in Supplemental Life or to increase your Supplemental Life coverage. Please contact Human Resources to obtain a Statement of Health Form and return it once completed.

LIFE INSURANCE IN EXCESS OF $50,000
If your life insurance coverage is in excess of $50,000 you will be taxed on the value above $50,000 known as imputed income as determined by the IRS. The taxable amount will appear on your paycheck and on your W-2.

ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE

Benefit-eligible employees are able to select ½, 1, 1 ½, or 2 times their annual base salary for AD&D insurance. The designated beneficiary (ies) will receive a lump sum payment in the event of the employee's accidental death. The employee will receive a one-time lump sum payment if dismembered (ex. loss of an eye or limb).

Once you have purchased the Supplemental Life insurance for your spouse and eligible dependents, you may also purchase AD&D for them.

If your term life insurance under this plan terminates, you will have an opportunity to convert your term coverage to an individual permanent policy ("conversion").

Coverage is provided under a group insurance policy issued to your employer by MetLife. Supplemental Life coverage under your employer's plan terminates when your employment ceases, when your Supplemental Life contributions cease, or upon termination of the group contract by your employer upon prior written notice to MetLife. Supplemental Life Insurance does not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota) of an increase in coverage. (This exclusion does not apply in Missouri, Massachusetts and Washington.) This coverage may also be discontinued by MetLife for non-payment of premium or if participation requirements are not met.

DISABILITY INCOME PLAN

Sheppard Pratt provides disability benefits to protect your earnings in case of sickness or injury. If you become totally disabled due to a non-occupational sickness or injury and are unable to perform the duties of your regular occupation, you will receive income replacement based on a percentage of your basic earnings.

- Eligibility begins on the first day of the month after 6 months of employment
- This income replacement begins after 30 calendar days of total disability for Health System employees and after 14 calendar days for School Schedule employees and employees of the Physician's P.A. and continues until you are no longer totally disabled or as specified in the Duration of Benefits Schedule
- You will be eligible to receive 60% replacement of your salary if you are disabled for more than the indicated elimination period. The 60% of salary benefit is provided as part of the Core benefit. In order to provide this as an after-tax benefit the cost is added to your salary for tax purposes
- The maximum monthly benefit payable is $20,000.

Discovery Benefits
simplify.

Sheppard Pratt Health System

FSA and HSA Plan Year July 1, 2018 – June 30, 2019

Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) allow employees to pay for eligible health care and dependent care expenses with pretax income. The funds are used to reimburse employees for out-of-pocket health care and dependent child care expenses incurred during the benefit plan year.

Proof of payment may be required for reimbursement. Always save your receipts for tax purposes.

THREE FLEXIBLE SPENDING ACCOUNTS (FSA)

- Health Care Spending Account
- Dependent Care Spending Account
- Limited Health Care Spending Account (available only to employees electing the High Deductible Plan)

2018 - 2019 Maximum Contribution:

- $2,650 maximum to Health Care & Limited Health care Accounts
- $5,000 maximum to Dependent Care Account

Please Note: A doctor prescription is required for reimbursement of all over- the- counter medications.
Please see the Forms section of this booklet for required form.

HEALTH SAVINGS ACCOUNTS(HSA): ONLY FOR ELIGIBLE EMPLOYEES ENROLLED IN THE HIGH DEDUCTIBLE PLAN

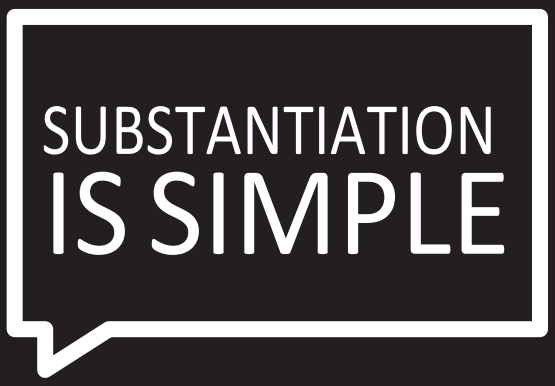
HSA (available only to those employees electing the High Deductible Plan and have no other health care coverage). Authorized by the IRS, a HSA is an individually owned, tax-advantaged savings plan that will help you manage your out of pocket healthcare expenses and can also be used as a retirement planning tool.

2018 - 2019 Maximum Contributions:

$3,450 if enrolled in employee only coverage
$6,900 if enrolled in employee plus dependent(s) coverage
If you are age 55-65, you may contribute an additional $1,000

Sheppard Pratt contributes $500 for individual coverage and $1,000 for Employee plus dependent coverage annually. These amounts are pro-rated based on the coverage effective during the plan year.

Guide to Substantiating Debit Card Transactions



There are several ways to submit documentation.

Online

Uploading is a quick, efficient way to submit documentation, and it only takes a few minutes.

Step 1: Log in.

Step 2: Click on Receipt(s) Needed under the Home tab.

Step 3: Click on Upload Receipt beside the claim to which you would like to upload your documentation.
Please note: The maximum file size for an upload is 2MB, and the receipt must be in a JPG, GIF, PNG or PDF format.

Step 4: You will be prompted to upload supporting documentation. Browse your documents and select the correct attachment. Once documentation is attached, select Upload.

Step 5: Once uploaded, you will receive confirmation and you will see a receipt status of Uploaded for that claim. This means your documentation has been submitted and will be processed within two business days. If further documentation is needed, you will be notified via email. If an email address is not on file, you will be notified via mail.

Fax or Mail

Submit the Receipt Reminder with documentation to Discovery Benefits via fax or mail.

Fax: 1-866-451-3245

Mail: Discovery Benefits, PO Box 2926, Fargo ND 58108-2926

Flexible Spending Account (FSA) FAQ — Participants

What is a Flexible Spending Account (FSA)?

An FSA works like a personal expense account. You set aside a portion of your salary before taxes and decide how much you want to contribute up to the maximum set by your employer or the IRS. Contributions are used to pay certain dependent care and medical expenses.

What are the different types of FSAs?

The most common types of FSAs include:

- Dependent Care Account (DCA): Allows reimbursement of dependent care expenses incurred by eligible dependents. To qualify, you and your spouse (if applicable) must be employed full-time or your spouse must be a full-time student.
- Medical Spending Account (MSA): Allows reimbursement of qualifying medical expenses.
- Limited Medical Spending Account (LMSA): Works in conjunction with a qualified High-Deductible Health Plan (HDHP) and Health Savings Account (HSA). Limited FSAs only allow reimbursement for preventative care, vision and dental expenses.

Please check with your employer to see which plans are offered.

Where can I find out which expenses are eligible for reimbursement?

Please visit our website at www.discoverybenefits.com/eligibleexpenses to find our most up to date eligibility lists.

Note: Some over-the-counter products require a doctor's prescription. Also, due to frequent updates to the regulations governing FSAs and HSAs, this list does not guarantee reimbursement and is intended to be utilized solely as a guide.

Can I change my FSA election after the plan year starts?

Certain qualifying events allow an employee to either increase/decrease the election or begin/cease participation in the plan. Common qualifying events include marriage, divorce, birth, death or a change in the cost of dependent care.

The adjustment to the election must be consistent with the event. For example, an increase in the cost of daycare would not allow you to decrease your election; however, if the increase made the cost of care unaffordable, one could justify no longer participating in the plan.

Please refer to your employer's Plan Document for further guidance on qualifying status change events applicable to your plan.

Whose expenses can I claim under my reimbursement account?

You can use your FSA to pay for eligible expenses incurred by any of the following individuals:

- Yourself
- Your spouse
- A qualifying child
- A qualifying relative

Special rules allow a dependent to be eligible for the plan even when that dependent does not qualify to be claimed as your tax dependent on your tax return. Discovery Benefits recommends that you check with your tax advisor before you make your election for the plan year.

Flexible Spending Account (FSA) FAQ — Participants, continued

May I use the Medical FSA to reimburse my spouse's deductible and/or co-payment expenses, even if he/she is enrolled in a different health insurance plan?

Yes. All eligible out-of-pocket medical expenses incurred by you and your qualified dependents can be reimbursed by your Medical FSA, even if such dependents are not enrolled in your employer's health insurance plan.

When and why do I need to substantiate benefits debit card transactions?

Due to IRS regulations, certain benefits debit card transactions need to be substantiated. Substantiating means validating the transaction to ensure the card was used for IRS-approved items/services within the allowed timeframe.

Substantiation is generally not needed when the transaction is one of the following:

- A co-payment tied to your health plan.
- Made at a merchant that utilizes the Inventory Information Approval System (IIAS). (A list of IIAS merchants can be found at www.discoverybenefits.com/IIAS.)
- A recurring expense that matches the provider and dollar amount for a previously substantiated claim.

You will be notified in writing if substantiation is required.

How can I be reimbursed for out-of-pocket expenses?

If you do not use your benefits debit card, you can file claims for out-of-pocket expenses in three ways:

- Online
- Using the Out-of-Pocket Reimbursement Request Form
- Via the Discovery Benefits mobile application

How will I be reimbursed for claims that I file?

There are two reimbursement options:

- Direct deposit
- Check (can be sent to you or the provider)

What if my Medical FSA expense is denied?

Participants will receive a notification if a claim is denied. You may also view your account online at www.discoverybenefits.com or call Participant Services to determine if you need to substantiate a claim and provide additional details. For an expense to be approved, the following information will need to be provided with documentation.

- Date service was received or purchase was made
- Description of service or item purchased
- Dollar amount
- Provider or store name
- In some cases, a Medical Necessity Form or physician letter may be required

Examples of expenses that may require these steps include health club membership dues, massage therapy and weight loss program dues. Expenses deemed medically necessary by the IRS are allowable; however, expenses for general health — even if doctor-prescribed — are not considered medically necessary by the IRS. For example, if you suffer back pain and your doctor confirms massage therapy is medically necessary to treat the back pain, the medical expense will be allowed, but massages for general wellness will not be allowed. Ultimately, it is the responsibility of the participant to submit claims for allowable expenses that are deemed medically necessary by the IRS.

How do I claim travel expenses for medical visits (mileage, parking, toll fees, etc.)?

To claim travel expenses for medical visits, submit a claim online or using the Out-of-Pocket Reimbursement Request Form.

What is the mileage rate?

1/1/2016 - 12/31/2016: 19 cents/mile
1/1/2017 - 12/31/2017: 17 cents/mile

How can I find out the balance of my FSA account?

You can access your balance in three ways:

- Log in to your account.
- Call 866-451-3399 and follow the voice prompts for balance information.
- Contact Participant Services via email or phone.

How do I log in to my account?

You can access you online account from our website at www.discoverybenefits.com.

What happens if my employment terminates?

Your employer will communicate your final service date to Discovery Benefits. Then, debit card functionality (if offered by your employer) will be shut off on the designated date. Please refer to your employer's Plan Document for further guidance on the amount of time given to file claims.

Guide to the Discovery Benefits Mobile Application

Downloading the Mobile Application

The Discovery Benefits mobile application can be downloaded for free on Android and Apple devices. Search for "Discovery Benefits" to locate the app in your phone's online store.

Logging In

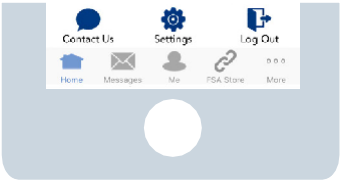
When the app is opened for the first time, you will need to enter the username and password for your Discovery Benefits portal. After you have successfully logged in to the mobile app for the first time, you will be prompted to set up a four-digit PIN. From that point forward, you'll be able to access the mobile app simply by entering this PIN.

The Home Screen

From the app's home screen, you will see options to file a claim, review and pay expenses or get a quick view of your account information. You'll also see an "All Accounts" section that lists the plans you are currently enrolled in, along with plan dates and balance information. To access more details about individual plans, simply tap the name of the plan that you wish to learn more about. If you click on a plan from the home screen, you will be brought to the "Account Details" page, where you can access current plan balance, plan dates and claim history.

The Menu

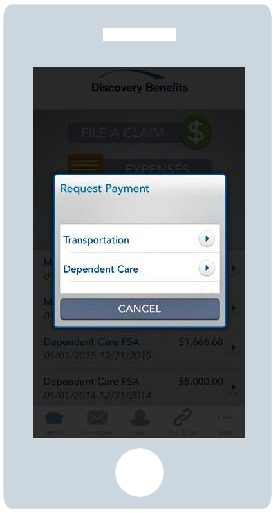
The menu bar is located at the top of the screen on Android devices and the bottom of the screen on iOS systems, and it is visible from any page of the mobile app. From the menu, you can access your home screen, the message center, your personal profile, a quick link to the FSA Store, Discovery Benefits' contact information, app settings and logout capabilities.

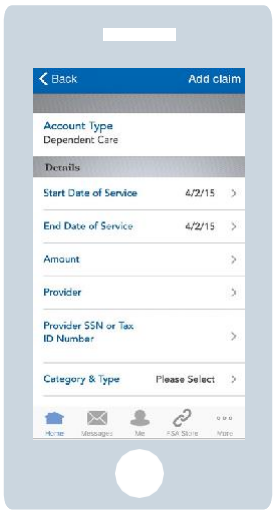


Guide to the Discovery Benefits Mobile Application, continued

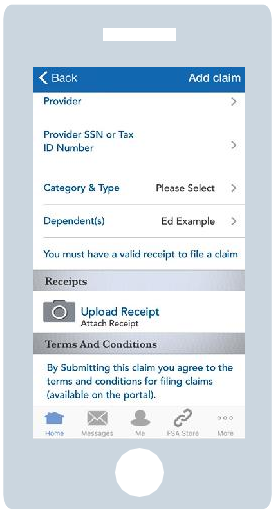
Claim Filing

To file a new claim for reimbursement, simply tap the "File a Claim" option from the home screen. If you have multiple accounts, you will be asked to select the account from which you'll be requesting payment.





After selecting the appropriate account for your claim, you will be directed to a screen where you can enter your claim details. Scroll down on this screen to upload the itemized receipt associated with your claim.

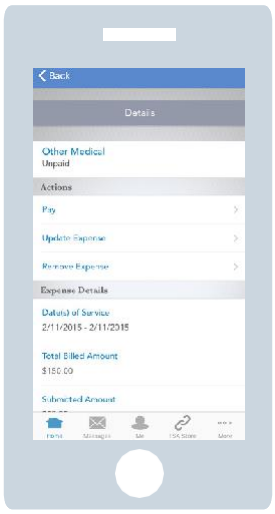


When you select the "Upload Receipt" option, the camera on your device will automatically activate to allow you to take a picture of your documentation, or you may upload a picture from your camera roll.

Once you have successfully captured or uploaded a photo of the documentation, your claim will be submitted for processing.

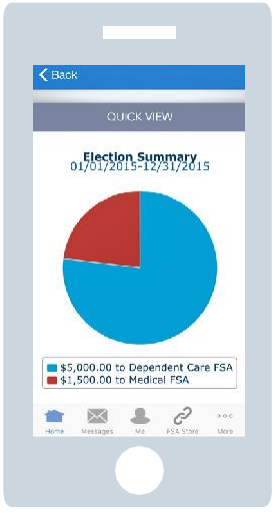
Dashboard

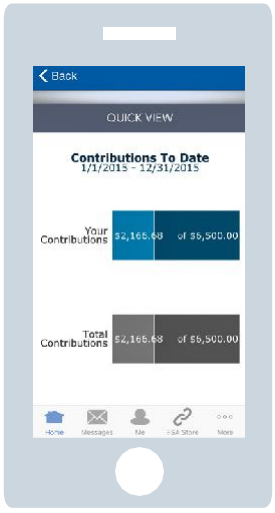
To access your expenses, tap the "Dashboard" option from the home screen. You will then be directed to the Dashboard screen, where you can track relevant expenses and save the associated documentation. The Dashboard allows you to add expenses for record keeping purposes. You can also pay out expenses from this screen.



Quick View

To access a quick view of your account details, tap the "Quick View" option from the home screen. The Quick View screen will provide you with basic information about your claims, elections and contributions. To see additional charts, you will need to swipe right from the "Paid Claims By Category" screen.



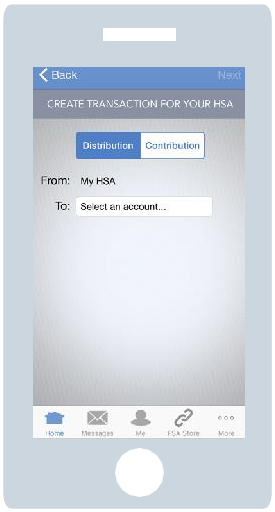


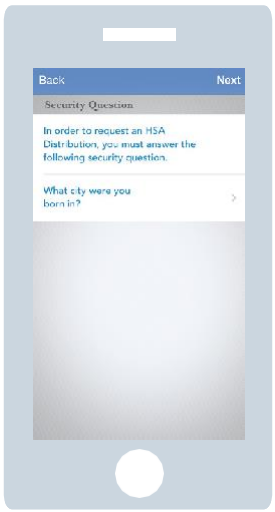
Guide to the Discovery Benefits Mobile Application, continued

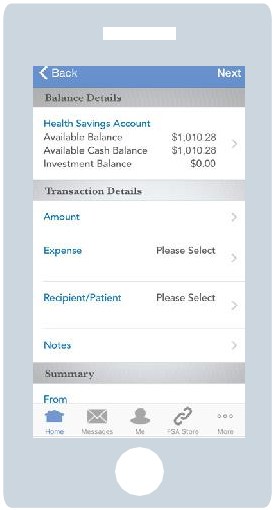
HSA Distributions

To request a new HSA Distribution, simply tap the "HSA Transaction" option from the home screen.

After selecting the "Distribution" option, you will be able to choose your reimbursement method from the drop-down menu. Once you have selected your reimbursement method, tap "Next" to continue with your distribution. You will then be prompted to answer a security question and directed to a screen where you can enter your transaction details.

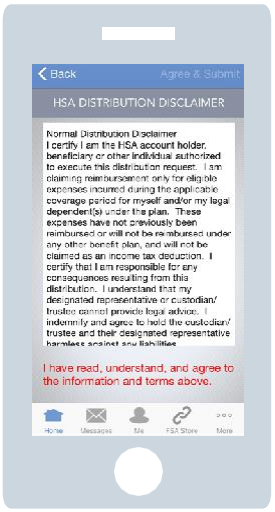






Once you have entered your transaction details, tap "Next" to read and agree to the HSA Distribution Disclaimer.

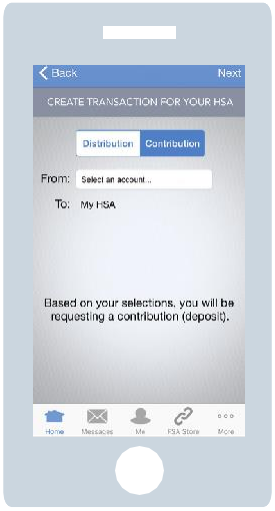
To agree to the disclaimer and submit your request, tap "Agree & Submit." A confirmation will appear once your transaction has been successfully submitted.

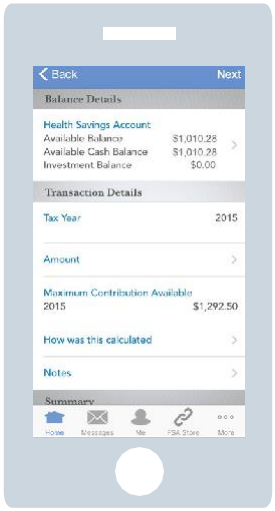


HSA Contributions

To add a contribution to your HSA from the mobile app, simply tap the "HSA Transaction" option from the home screen.

After selecting the "Contribution" option, select the account you would like the contribution to come from. Once you have selected the appropriate account, tap "Next" to continue with your contribution. You will then be directed to a screen where you can enter your transaction details.





Once you have entered your transaction details, tap "Next" to read and agree to the HSA Contribution Disclaimer. To agree to the disclaimer and submit your request, tap "Agree & Submit." A confirmation will appear once your transaction has been successfully submitted.

Guide to the Discovery Benefits Mobile Application, continued

Message Center

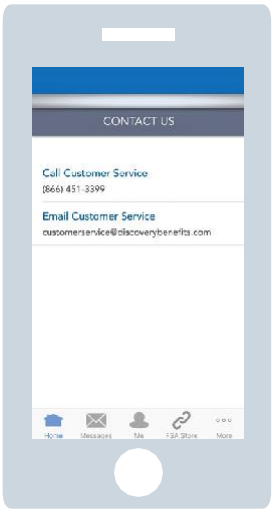
To access your Message Center, tap the envelope icon on the app's menu bar. If you see a red notification next to the envelope icon, this means you have one or more messages waiting for you in the Message Center. Your Message Center is where you can go to view claim information and any previously submitted documentation for outstanding claims currently requiring documentation. You can also upload required documentation for your outstanding claims from the Message Center page of the app.

Personal Profile

To access your personal profile from an Android device, expand the menu bar at the top of the screen and select "Me." To access your profile from an iOS device, simply click on the icon labeled "Me" on the menu bar at the bottom of your screen. From your personal profile page, you can view the name of the account holder, the date of your last login to the mobile app and any legal documentation available to you.

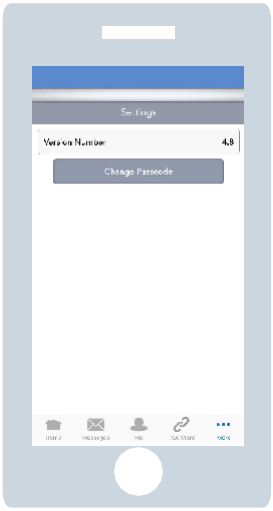
Contact Information

You'll find the "Contact Us" option in two places in the mobile app — both on the initial passcode screen and on the menu bar at the top (Android) or bottom (iOS) of your screen. Clicking on either of these will direct you to a screen containing the phone number and email address for Discovery Benefits' Participant Services team.



Settings

You can access your app's settings by clicking on the gear icon labeled "Settings" on the menu bar. This page is where you can go to change your passcode or see which version of the app you're using.



Sheppard Pratt Retirement Plans

Employees Hired Prior to July 1, 2006

The Pension Plan

Sheppard Pratt provides a Pension Plan for those employees hired prior to July 1, 2006 (in some cases, rehired employees may be eligible to be reinstated into the Pension plan, please contact the Benefits Department with eligibility questions). Normal retirement is age of 65 and early retirement can be at age 55 with ten years of service.

In addition to the Pension plan, The Sheppard Pratt Retirement Program offers eligible employees hired prior to July 1, 2006 the following options:

Part I – 403(b) Account Tax Sheltered Annuity
Part II – Thrift Plan (Savings Account)

For an employee hired after July 1, 2006 and not a Pension Plan Participant

The Sheppard Pratt Retirement Program offers eligible employees hired after July 1, 2006 a plan consisting of two components:

Part I – 403(b) Account Tax Sheltered Annuity
Part II – Thrift Plan (Savings Account and Retirement Account)

See below for descriptions of these accounts

Part I - 403(b) Tax Sheltered Annuity Account

All Sheppard Pratt employees may participate in a tax sheltered annuity program by making voluntary pre-tax contributions to a 403(b) retirement plan. This includes all employees, even if not currently eligible for the Thrift plan.

- 2018 maximum contribution limit to your plan is $18,500.
- For those 50 or older, you may contribute an additional $6,000.

All accounts are administered by: **Transamerica Retirement Solutions**

- Online at www.trsretire.com or call Transamerica Direct at 800-755-5801

- ***Complete Beneficiary forms and submit to Human Resources.***

- If you do not elect investment options, your deferral money will be sent to the default fund **PortfolioXpressSM**
- Employees may enroll into the 403(b) plan and change their elections and fund options at anytime
- Newly hired employees, who do not enroll in the 403(b) plan, will be auto-enrolled at 4% pretax payroll deduction unless the employee waives participation in the plan. To waive or make a change to the auto-enroll amount, employees must call or go online to www.trsretire.com within the first 30 days of employment
- Unless otherwise directed by the employee, these funds will go into the default fund **PortfolioXpressSM**

In addition to the 50 and over catch-up contributions, you may be eligible to exceed the applicable annual salary deferral limit by an additional amount of $3000 if you have 15 or more years of service with Sheppard Pratt Health System. A calculation will be needed to determine if you are eligible to take advantage of the catch-up election.

Please contact Transamerica at 888.676.5512 to request a 403(b) Contribution Planner Worksheet. Once Transamerica receives the completed worksheet, the calculation will be performed to determine your eligibility. This calculation will need to be completed annually as there are limitations as to the total dollar amount that can be contributed under this election.

Part II - Thrift Plan for Employees Hired Prior to July 1, 2006

Savings Account

- Sheppard Pratt makes an annual determination as to whether a matching contribution of 50% of deferrals up to 1% of compensation will be made for the 403(b) plan participants
- This is considered a discretionary contribution
- This is a separate account from your 403(b) account
- Employees have the choice of thirteen investment funds in their Thrift Plan Savings Account, which is currently administered by Transamerica Retirement Solutions

Part II - Thrift Plan for Employees Hired After July 1, 2006

Savings Accounts

- Sheppard Pratt makes an annual determination as to whether a matching contribution up to 2% of compensation will be deferred for the 403(b) plan participants
- This is considered a discretionary contribution
- This is a separate account from your 403(b) account
- Employees have the choice of the same thirteen investment funds as available for the 403(b) plan in which to invest their Thrift Plan Savings Account

Retirement Account

- Sheppard Pratt contributes an annual amount based upon a point value equal to the sum of the employee's age and years of service
- Employees are not required to make any contributions in order to receive the Retirement Account contribution. This is considered a non-discretionary contribution.

Retirement Account Formula:

- 3.5% if age and service is less than 45 combined
- 5% if age and service is between 45 but less than 65 combined
- 8% if age and service is 65 or more combined

Vesting Schedule for all Thrift Plan contributions:

- 2 years…….. 25% vested
- 3 years…….. 50% vested
- 4 years…….. 75% vested
- 5 years…….. 100% vested

To be eligible for the Thrift Plan employer contributions the employee must:

- complete at least 1000 hours of work during the plan year
- be employed on the last day of the plan year (June 30)

This information is only intended as an overview. Please consult the Summary Plan Descriptions for the various plans. Please contact your Benefits Department with any questions.

CYBERSECURITY BEST PRACTICES

Cybersecurity incidents and data breaches in the U.S. are at an all-time high. Transamerica is committed to safeguarding the privacy and personal information of all our customers. We take numerous precautionary steps to protect personal data, including routine security evaluations and enhanced security for certain systems.

You can play an important role in helping reduce the risk of a cyber-attack. Below, we've outlined a few simple principles of what we like to call "good cyber hygiene" that you can adopt to help keep financial information secure.

CREATE COMPLEX PASSWORDS AND CHANGE THEM FREQUENTLY.

If you have not done so already, it is important that you establish login credentials for your online accounts. Wherever possible, use complex passwords that are at least eight (8) characters long and mix numbers, upper and lowercase letters, and symbols. Make your passwords unpredictable. Change passwords often and avoid using the same password on other websites. Do not use names, dates or words related to you. Remember not to share your passwords with anyone else – passwords should be for your eyes only.

MAKE SURE YOU HAVE UP-TO-DATE SECURITY SOFTWARE AND REGULARLY RUN VIRUS CHECKS ON YOUR COMPUTER.

Good protection software provides 24/7 online safety against malicious software by preventing harmful malware from coming into contact with your computer system. Outdated software makes you vulnerable to attack, so keep your software – including your operating system, web browsers and apps – up to date to protect against the latest threats. Use a firewall – a software program or piece of hardware that helps protect your computer.

BEWARE OF PHISHING SCAMS THAT ASK YOU TO PROVIDE PERSONAL INFORMATION IN EMAILS, TEXT AND POP-UPS.

Reputable companies won't request confidential information or ask you to reset a password over email. These requests are key indicators of likely phishing scams. Be cautious about opening attachments or clicking on links in emails. These links could not only harm your computer, but also expose personal data and any other information stored on your computer. Instead, verify the URL of the company's website, open a new browser window and type the verified URL directly into the address bar.

REMAIN VIGILANT AND REGULARLY REVIEW ACCOUNTS AND CREDIT REPORTS FOR ANY UNAUTHORIZED ACTIVITY.

Review all account statements on a regular basis. Use available confirmations and alerts to catch anything suspicious in real time. Unusual or unauthorized activity could indicate that someone has stolen personal details or committed fraud. That's why it's important to monitor your credit profile. For more information about identity theft, visit https://www.identitytheft.gov/steps.

For additional information on how you can protect your networks and personal computing devices, visit the federal government's website www.OnGuardOnline.gov.

TRANSAMERICA®

providing easy access to your account

Whether you prefer a laptop, desktop, tablet, or smartphone, you can access your Transamerica account when you want, how you want, where you want.

YOU CAN MANAGE MORE ASPECTS OF YOUR ACCOUNT ONLINE OR OVER THE PHONE STARTING .

You can review the current status of your account, make changes, and access tools to help you personalize your retirement strategy.

Download the My TRSRetire app from the App Store or Google Play

With the My TRSRetire app, connecting with your retirement plan has never been easier.

- View your account balance and rate of return
- Know *Your Retirement Outlook®*
- Model ways to improve your forecast and take action

ONLINE ACCESS

my.trsretire.com

Sign in:

First-time users

Step 1: Select "**New user? Get started.**"

Step 2: Follow the instructions to establish a username and password.

Frequent users

Step 1: Sign in to your account by entering your username and password.

Step 2: Click on the name of the account you want to access.

ONCE YOU'RE IN:

From the left-hand menu, scroll over the five tabs – **Home**, **Review**, **Manage**, **Are You *OnTrack®***, and **Resource Center** – and select an option from the drop-down lists.

Check account balance

- Balance automatically appears on the overview page.
- For account balance by fund, click "**Balance**."

Review investment performance

- To get performance and fee details for all the funds in your plan, click "**Fund and Fee Information**" under the **Manage** tab.

Change contribution amount

- To choose or change your contribution amount and sign up for annual, automatic increases, click "**Contributions**" under the **Manage** tab.

You should evaluate your ability to continue the auto-increase service in the event of a prolonged market decline, unexpected expenses, or an unforeseeable emergency.

Change future investment allocations (new contributions)

- To choose or change how new contributions will be invested, click "**Future Allocations**" under the **Manage** tab.

Transfer Between Investment Options (current assets)

- To transfer balances between individual or groups of funds, click "**Transfers**" under the **Manage** tab.
- To change your overall investment mix, click "**Current Investments**" under the **Manage** tab.

Get loan details

- To review loan status and get payoff details for current loans (if applicable), click "**Loan Details**" under the **Review** tab.

Name or change a beneficiary

- To name or change your beneficiary, click "**Beneficiaries**" under the **Home** tab.

Please note that if you are married and designate someone other than your spouse as a "primary" beneficiary, spousal consent may be required.

When you enter a change, a confirmation will be sent the following business day. Changes that are completed prior to 4 p.m. ET will be valued using the market closing unit values for that day. Changes completed after 4 p.m. ET will be valued using the market closing unit values for the following business day.

TRANSAMERICA®

access by phone

VOICE PASS

Our voice-recognition system can provide security and convenience without having to remember a password when you call our Customer Care team. Voice Pass will identify you based on a stored voiceprint as unique as your fingerprint. Once set up, all you'll need to do when you call is repeat the phrase: "At Transamerica, my voice is my password" to access your account.

Call US:

Step 1: Call **800-755-5801**.

Step 2: Let us know who you are. If you're calling from the phone number we have on file, we'll identify you that way. If you're calling from a different phone number, enter or say your Social Security number.

Step 3: If it's your first time calling, follow the prompts to set up Voice Pass.
If you've called us before, we'll ask you to verify your identity using your voice.

ONCE YOU'RE IN:

After verifying your identity, you can navigate the phone system by saying what you want to do. Here are a few examples:

- Check account balance
- Change contribution amount
- Get loan information or model a loan
- Access customer service

When you enter a change, a confirmation will be sent the following business day. Changes that are completed prior to 4 p.m. ET will be valued using the market closing unit values for that day. Changes completed after 4 p.m. ET will be valued using the market closing unit values for the following business day.

Get in touch:

CALL
800-755-5801

VISIT
my.trsretire.com

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TRANSAMERICA

Brighten Your Outlook®

Stay on Top of Your Retirement Planning

Sheppard Pratt HEALTH SYSTEM

Designate your beneficiary today

For more information on designating your beneficiary, call 800-755-5801.

As much as we'd all like to live forever, it's important to plan for the future. Please take a couple minutes to name at least one beneficiary on your retirement plan account. It could save time, money, and frustration down the road.

Why it's important

A will can be an excellent estate-planning tool, but it doesn't cover assets held within retirement savings plan accounts. This could lead to added stress and administrative work for your heirs, so it's important to establish and maintain a retirement plan beneficiary designation separate from your will.

Designating your beneficiary is easy

Sign in to your account at my.trsretire.com to print a beneficiary form, call 800-755-5801 to have one mailed to you, or request one from your employer. Complete the form and follow the instructions at the top for obtaining the required signatures and for mailing.

Please note you might need spousal consent if you designate a primary beneficiary other than your spouse.

Keep your designation current

Life's circumstances are always changing – sometimes quicker than we expect. Pick a date to review your beneficiaries annually. Some people choose their birthdays, New Year's Day, or their favorite holiday.

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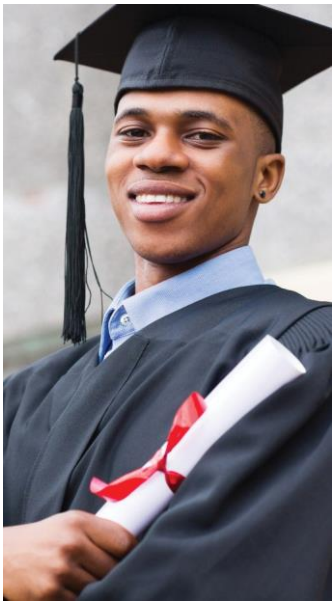

When you need to borrow or save money, we've got your best *interest* in mind!

The Credit Union philosophy of *"people helping people"* is demonstrated by the **low** or **no-fee** financial services that make everyday money management less stressful for our members.

And, our friendly staff is ready to assist—listening and helping you choose the services best suited to *your* needs. Whether you're looking to finance a Home or Automobile, or open a convenient Checking Account...we're here to help! Some of our most popular member services include:

- **Home Mortgages, Vehicle and Motorcycle Loans**
- **VISA Platinum Credit Card with No Annual Fee**
- **Checking with free Online/ Mobile Banking and Bill Pay**
- **SmartCash Check Card tied to over 55,000 ATMs**
- **Direct Deposit, Automatic Transfers, and more!**

Not already a member? Visit us at www.bcefcu.com to learn more about the many financial products and services now available to the employees of the **Sheppard Pratt Health System**. With three locations to serve you and your family, we look forward to seeing you soon!

Your Finances. Our Promise.

Baltimore County Employees Federal Credit Union

WWW.BCEFCU.COM

23 W. Susquehanna Ave., Towson, MD 21204
8640 Ridgely's Choice Drive, Baltimore, MD 21236
6535 N. Charles Street, Baltimore, MD 21204
410-828-4730 | 1-800-234-4730

Your savings federally insured to at least $250,000 and backed by the full faith and credit of the United States Government
NCUA
National Credit Union Administration, a U.S. Government Agency

EQUAL HOUSING LENDER

EMPLOYEE ASSISTANCE PROGAM

KEPRO INTELLIGENT VALUE

SHEPPARD PRATT HEALTH SYSTEM

COUNSELING SERVICES Counseling sessions are available for issues affecting employees and their dependents. Individuals may speak with a professional counselor by phone, and the Employee Assistance Program will provide a referral to see a local counselor at no cost for issues such as:	• Anxiety and stress • Depression • Grief • Parenting • Drug or alcohol abuse	• Transition and change • Relationships –individual, marital, and family
FAMILY CAREGIVING SERVICES Confirmed referrals and information are available on a variety of family matters, including:	*CHILD CARE ANDPARENTING* • Prenatal care • Daycare/summercamps • Special needs services • Preparing students for college	*ELDERCARE* • Assisted living • In-home care • Transportationservices • Adult daycare
LEGAL SERVICES A 30 minute phone or in-person consultation is available to help answer basic legal questions and simplify the process of obtaining legal help. Some common legal concerns include:	• Adoption • Bankruptcy • Child custody • Criminal issues • Divorce	• Estate Planning • Immigration • Real estate • Tenant's rights • Mediation
FINANCIAL SERVICES A telephonic consultation with a qualified financial consultant is available to assist with a variety of financial concerns such as:	• Bankruptcy alternatives • Budgeting and cash flow • Credit issues • Identity theft	• Education funding • Income taxes • Mortgages • Retirement planning
CONVENIENCE SERVICES The Employee Assistance Program includes complimentary referrals to convenience services to help members make the most of their money and free time.	• Repairs • Moving and relocation services • Cleaning services • Car and hotel reservations • Sightseeing tours	• Destination guides • Dining • Personal shopping • Gift Recommendations
ONLINE TOOLS AND INFORMATION EAPHelplink.com is an interactive web-based self-service solution. The site provides a wide array of life management tools to help members with a variety of personal and/or work related issues in a private and convenient manner.	• Research articles • Wellness articles • Online trainings • Monthly webinars	• Self-search locators forchild, academic and adult care resources • And much more!

CONFIDENTIALITY: All discussions between you and your EAP professional are confidential. Information regarding your contact with the EAP cannot be released without your written consent, except by court order, imminent threat of harm to self or others, or in situations of abuse (such as child or elder abuse).

NO OUT-OF-POCKET COST: Your EAP is offered at no cost. Most concerns can be resolved directly with your EAP professional, but in the case that additional services are needed, your EAP professional will work with you to identify the most appropriate and affordable community resource to help meet your needs. Please note that referrals to services outside the EAP benefit may require out-of-pocket cost.

For more information about your Employee Assistance Program please contact us as listed below.

Phone: 800-765-0770 **Website: www.EAPHelplink.com** **Company Code: SPHS**

Employee Assistance Program

Legal/Financial Consultation and Referral Services

Answers to Your Legal and Financial Questions

Why is there a need for Legal and Financial Consultation and Referral Services?

- Family problems and daily living issues often include financial or legal components
- According to the American Bar Association, one out of every three adults has a need for legal advice during the year
- Legal concerns can be stressful, costly, and often result in lost worktime

What does Legal and Financial Consultation and Referral Services provide?

- Up to 30 minutes of legal consultation with an attorney or financial counselor at no cost or obligation

What Legal Services are Available?

- Face-to-face or telephonic consultation with an attorney
- Use of the services for up to three times in a calendar year for separate legal matters
- Discounted rates up to 25% if the attorney is retained after the free legal consultation

What issues can Legal and Financial Services help with?*

- Civil/Consumer Issues – collection/repossession, contractual disputes, defaults, foreclosures, product liability, traffic violations, and civil rights
- Personal/Family Legal Services – adoption, child custody, divorce, domestic violence, eldercare
- Business Legal Services – insurance, copyrights, patents, and contracts
- IRS Matters – IRS specialists able to negotiate with IRS on your behalf
- Real Estate – consultation on home purchases and closings, construction, and property easements
- Credit/Debit Services – renegotiating debt, correcting credit reports, and assisting with collection activities
- Estate Planning – no cost consultation with a Financial Counselor
- Financial Planning – one 30-minute telephonic financial planning consultation with a Financial Counselor at no cost

** Matters involving disputes or actions between employees, dependents, or household members and their employer are specifically excluded from eligibility of this plan.*

To access these services, call the toll-free number listed below or visit us online.

www.EAPHelplink.com

Company Code: SPHS

1.800.765.0770

Sheppard Pratt HEALTH SYSTEM

SHEPPARD PRATT HEALTH SYSTEM
LIFE, ACCIDENT AND HEALTH PLAN
SUMMARY OF MATERIAL MODIFICATIONS

To: Participants in the Sheppard Pratt Health Plans

From: Karen Robertson-Keck, Vice President, Human Resources

Date: March 26, 2018

Re: Changes to the Health Plans effective as stated below

This Summary of Material Modifications ("SMM") describes certain changes made to the Sheppard Pratt Life, Accident and Health Plan. This SMM formally amends portions of the applicable "Custom Options" available, which previously were provided to you as part of the Plan's Summary Plan Descriptions ("SPD") or certificates. Therefore please attach this SMM to your copy of the appropriate Plan's SPD or certificate. These changes are effective as stated below.

The Sheppard Pratt Health System Summary Plan Description for the Cafeteria Plan effective July 1, 2017 is hereby amended by resolution adopted and executed by Sheppard Pratt Health System ("the Employer').

I. Effective April 1, 2018:

For the Health and Dependent Care Flexible Spending Accounts, you must submit all claims no later than September 30, or 92 days, after the end of the Plan Year (July 1st through June 30th). Any claims submitted after September 30th will not be considered

If you terminated employment during the Plan Year, you must submit all Health and Dependent Care Flexible Spending Account claims within 90 days after your coverage end date. Any claims submitted after that time will not be considered. This is to provide timely processing of claims.

The Sheppard Pratt Health System Summary Plan Description for the Standard, Premium and High Deductible Plans and the Vision Plan; the Sheppard Pratt Summary Plan Description for the Concordia Preferred Dental Plan; the United Concordia DHMO coverage certificate; and (for # I only) Basic Life Insurance, Optional Life Insurance and Optional Accidental Death and Dismemberment Insurance certificates effective July 1, 2017 are hereby amended by resolution adopted and executed by Sheppard Pratt Health System ("the Employer').

I. Effective July 1, 2018

A. Coverage for eligible Employees (and their Dependents for whom coverage is elected) who have properly completed an enrollment application during their initial enrollment period is effective on the later of the following dates:

1 The Plan's Effective Date;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire **to the first of the month following 30 days of continuous employment**.

To become covered by the Plan, you must complete an on-line enrollment form. During your new Employee orientation, or if your employment status changes so that you become eligible to participate in the Plan, you will be given information and instructions to complete an on-line enrollment through the web. You must complete the enrollment

within 31 days from your date of hire or within 31 days from your eligibility date for status changes.

B. Additional provision for Dependent Coverage Termination:

In the event of an Employee's death during any month, dependent coverage will terminate on the last day of that month. This is to clarify that coverage does not end on the date of Employee's death, but rather continues to the last day of that month.

C. Eligible Dependents:

Children under age 26 – without regard to dependency and without regard to marital status – shall be considered dependents for the purposes of Medical/Prescription benefits **and Vision benefits offered under the Plan and Dental benefits offered under the Concordia Preferred Dental Plan and United Concordia DHMO Plan**.

A copy of the Sheppard Pratt Health System Summary Plan Description and the Sheppard Pratt Health Cafeteria Plan, effective as of July 1, 2017, and this Summary of Material Modifications are posted to the Sheppard Pratt benefits web site at www.sphsbenefits.com

If you have any questions concerning this SMM, the Plan changes it summarizes, or your SPD, please contact the Plan Administrator at the following address:

Sheppard Pratt Health System
Division of Human Resources, Benefits Department
6501 North Charles Street
P.O. Box 6815
Baltimore, MD 21285
(410) 939-3300

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: a Sheppard Pratt Human Resources representative. You must contact Kelly and Associates Insurance Group by calling 1-866-696-4548 or email at cobrainfo@kellyway.com

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

If you have any questions regarding this notification of your COBRA rights, please feel free to contact Sheppard Pratt's Human Resources Department at 410-938-3376 during normal business hours. More information regarding your COBRA rights is available in the Summary Plan Description. You may also contact the COBRA Administrator for Sheppard Pratt: Kelly and Associates Insurance Group,
1 Kelly Way Sparks, Md. 21152. Cobra call center is 443-589-1862 or 866-696-4548, Fax is 410-527-5905
cobrainfo@kellyway.com

Your Information. Your Rights. Our Responsibilities.

PRIVACY NOTICE OF SHEPPARD PRATT LIFE ACCIDENT AND HEALTH PLAN

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

> Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

> Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

> Example: Your employer contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Items of Notice

- Effective Date of this Notice: September 23, 2013

Name or title of the privacy official (or other privacy contact) and his/her email address and phone number:

Sheppard Pratt Health System
Division of Human Resources, Benefits Department
6501 North Charles Street
Baltimore MD 21204
410-938-3300
Fax 410-938-3314
Attention: Privacy Officer: Life, Accident and Health Plan

- The Privacy Rule requires us to describe any state or other laws that require greater limits on disclosures. We will observe all Maryland laws, including Maryland's new privacy law, the Personal Information Protection Act, effective October 1, 2013.

Important Notice from Sheppard Pratt Health System about Your Prescription Drug Coverage and Medicare

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

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

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

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

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 Sheppard Pratt Health System coverage will not be affected. Your current prescription coverage with Sheppard Pratt group health plan will coordinate with Part D coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription drug coverage in your area.

Your current Sheppard Pratt Health System coverage pays for health expenses including hospital, medical and prescription drugs. If you do decide to join a Medicare drug plan **and** drop your current Sheppard Pratt Health System coverage, be aware that you and your dependents will be able to get this coverage back provided that you satisfy the current eligibility rules of the Sheppard Pratt Health System Medical Plans.

If you do decide to join a Medicare drug plan and drop your current Sheppard Pratt Health System coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Sheppard Pratt 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.

More information about this Notice or your current Prescription Drug Coverage...

Contact our Division of Human Resources for further information at 410.938.3300. 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 Sheppard Pratt Health System changes. You also may request a copy of this notice at any time.

More information about your options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You[11] handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	April 15, 2018
Name of Entity/Sender:	Sheppard Pratt Health System
Office:	Human Resources, Benefits Dept.
Address:	6501 N. Charles Street, Baltimore, MD 21204
Phone Number:	410.938.3300

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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

SHEPPARD PRATT HEALTH SYSTEM
DIVISION OF HUMAN RESOURCES

NOTICE OF REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

The following information is being supplied to you to satisfy notice requirements of the Women's Health and Cancer Rights Act of 1998. It describes coverage which is already being provided by our Group Health Plans.
In compliance with the Women's Health and Cancer Rights Act of 1998, the following benefits are provided to all Plan participants who elect breast reconstruction in connection with a mastectomy:

1. Reconstruction of the breast on which the mastectomy has been performed,
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

Normal Plan deductible and coinsurance, if any, will apply. If you are a member of the Premium, Standard or High Deductible Plans, you should contact Allegeant, LLC or refer to the Summary Plan Description and Schedule of Benefits for detailed information regarding your coverage under the Plan.

The Plan will not deny eligibility, or continued eligibility, to enroll or to renew coverage under terms of the Plan, solely to avoid providing the above benefits. Further, the Plan will not penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care to an individual participant or beneficiary in a manner which is inconsistent with the Women's Health and Cancer Rights Act of 1998.

NOTICE REGARDING WELLNESS PROGRAM

Sheppard Pratt Health System Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA.

However, employees who choose to participate in the wellness program for Plan year beginning July 1, 2018 will receive a discount on their premium of 5% of the total cost of employee only coverage as shown in the annual Open Enrollment and New Hire packets for completing the requirements which include completing an HRA, having an annual physical, completing any 2 events, action plans or challenges on AllegeantWellness.com, and identifying a Primary Care Physician. Although you are not required to complete the HRA, only employees who do so along with the other requirements will receive the incentive.

Additional incentives of up to 5% for the total cost of employee only coverage are available for both the employee and spouse who certify an affidavit as a non-smoker. The discounts are shown in the annual Open Enrollment and New Hire packets. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Allegeant at 800-553-8635.

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

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Patti Arkuszedki at Sheppard Pratt Human Resources, (parkuszeski@sheppardpratt.org, or 410-998-3317).

			Sheppard Pratt Health System*			
			FISCAL 2018 - 2019 (7/1/2018 to 06/30/2019)			
			BEGIN PERIOD	END PERIOD	**PAY DATE**	
	BW	14	06/24/18	07/07/18	**07/13/18**	
	BW	15	07/08/18	07/21/18	**07/27/18**	
	BW	16	07/22/18	08/04/18	**08/10/18**	
	BW	17	08/05/18	08/18/18	**08/24/18**	
	***BW**	**18**	**08/19/18**	**09/01/18**	**09/07/18**	
	BW	19	09/02/18	09/15/18	**09/21/18**	
	BW	20	09/16/18	09/29/18	**10/05/18**	
	BW	21	09/30/18	10/13/18	**10/19/18**	
	BW	22	10/14/18	10/27/18	**11/02/18**	
	BW	23	10/28/18	11/10/18	**11/16/18**	
	BW	24	11/11/18	11/24/18	**11/30/18**	
	BW	25	11/25/18	12/08/18	**12/14/18**	
	BW	26	12/09/18	12/22/18	**12/28/18**	
	BW	1	12/23/18	01/05/19	**01/11/19**	
	BW	2	01/06/19	01/19/19	**01/25/19**	
	BW	3	01/20/19	02/02/19	**02/08/19**	
	BW	4	02/03/19	02/16/19	**02/22/19**	
	BW	5	02/17/19	03/02/19	**03/08/19**	
	BW	6	03/03/19	03/16/19	**03/22/19**	
	BW	7	03/17/19	03/30/19	**04/05/19**	
	BW	8	03/31/19	04/13/19	**04/19/19**	
	BW	9	04/14/19	04/27/19	**05/03/19**	
	BW	10	04/28/19	05/11/19	**05/17/19**	
	BW	11	05/12/19	05/25/19	**05/31/19**	
	***BW**	**12**	**05/26/19**	**06/08/19**	**06/14/19**	
	BW	13	06/09/19	06/22/19	**06/28/19**	
	No FSA or HSA contributions for hospital & P.A. employess					
	BW24 (11/30/18) & BW11 (5/31/19)					
	No FSA or HSA contributions for school schedule employees					
	BW24 (11/30/18)					
	Pays for 10 month school schedule employees					
	***BW18 (9/7/18) - BW12 (6/14/19)**					