HONORHEALTH™

2016 OPEN ENROLLMENT GUIDEBOOK

Open Enrollment for HonorHealth

November 1 – 21, 2015

Welcome to Open Enrollment 2016

We are excited to share our benefit offerings for 2016. Our benefit offerings remain consistent from the prior year, and we enriched programs in a few key areas. We continue to work hard to preserve the benefits you rely on while maintaining affordable out-of-pocket costs.

The cost of your healthcare benefits is influenced significantly by your efforts to maintain good health and practice a healthy lifestyle. Your actions make important contributions to maintaining the cost and level of benefits you've come to expect. Your employee wellness program will continue to expand its offerings while it helps you understand your health risks and encourages healthy choices.

At HonorHealth, we are committed to your well-being and providing you and your family with a competitive benefits program.

Your Employee Benefits Department

Plan Contacts

The following chart lists benefit providers, customer service numbers and website addresses.

Provider	Service	Phone	Website
HonorHealth Employee Benefits		480-323-4667	www.honorhealth.com/employee-resources
AmeriBen	Medical claims administration and Flexible Spending Accounts	602-231-8855	www.myameriben.com
Blue Cross Blue Shield of AZ	Medical network		www.azblue.com/chsnetwork
PHCS Healthy Directions	Out-of-State medical network	800-678-7427	www.multiplan.com
EnvisionRX Options Orchard Pharm. Services	Prescription drugs Mail-order program	800-361-4542 866-909-5170	www.envisionrx.com www.orchardrx.com
Magellan Health Services	Behavioral health services administration	800-424-4138	www.magellanhealth.com/mbh
HealthEquity	Health Savings Account	866-346-5800	www.healthequity.com/shc
Teladoc	Online urgent care services	877-585-7828	www.teladoc.com
MetLife	Critical illness insurance Accident insurance	800-438-6388 800-438-6388	www.metlife.com/mybenefits
Delta Dental of Arizona	Dental plan	602-938-3131	www.deltadentalaz.com
Employers Dental Services - (EDS)	Dental plan	602-248-8912	www.mydentalplan.net
Vision Service Plan (VSP)	Vision plan	800-877-7195	www.vsp.com
UnitedHealthcare Vision Plan (UHC)	Vision plan	800-638-3120	www.myuhcvision.com
MetLife Legal Plan	Legal and financial services	800-423-0300 800-821-6400	www.legalplans.com (Click “Thinking about enrolling?” then enter password: metlaw)

Open Enrollment Information

Open Enrollment is
November 1 to 21, 2015

Review your current benefit elections. If you do not make changes, your benefits will remain the same with the exception of any FSA election.

Re-enrollment is NOT required this year for health, dental, vision, or any of the voluntary benefits offered.

You must always re-enroll in a
flex spending account
to obtain this benefit in 2016.

Changes you make during this open enrollment will be
effective January 1, 2016.

The following benefits may be added, dropped or changed during this Open Enrollment Period only: health plan, dental plan, vision plan, *flexible spending accounts, health savings account, accident plan, critical illness and legal plan.

* The flex spending account(s) benefit requires re-enrollment each year—it does not automatically continue without action from you. Please use the Open Enrollment tool on Staff Member Self Service to re-enroll.

A special Open Enrollment Period for voluntary life insurance for you or your dependents and long-term disability buy-up will be offered at another time. Additional details will be forthcoming.

For enrollment assistance:

- All Open Enrollment information will be available on the Internet, Intranet and Staff Member Self Service no later than November 1, 2015

For additional information about benefit plans:

- Visit the Internet, Intranet or Staff Member Self Service.

What's Changing in 2016?

These benefit changes will be effective January 1, 2016.

Health Plan	▪ Increase in the Alternative Benefit annual coverage from $750 to $1,000 per participant ▪ Increase Urgent Care access through the BCBSAZ network ▪ Emergency Room coverage 100% after co-pay regardless of the reason for the visit ▪ Autism coverage up to $25,000 per year, then additional co-insurance thereafter (new service; subject to applicable co-insurance) ▪ Prophylactic Mastectomy coverage with pre-approval (new service; subject to applicable co-insurance) ▪ Office consultation visits from covered physicians will now be covered at an office visit co-pay ▪ All BCBSAZ Anesthesiologist/Hospitalist/Pathologist/Radiologist physician services will be paid at the HonorHealth coverage level ▪ Outpatient rehab therapy services offered through BCBSAZ and HonorHealth providers will be paid at the same coverage level ▪ Increase bra/camisole coverage post mastectomy from 4 bras and/or camisoles per year to 6/per year ▪ Increase wigs/cranial prosthesis coverage from $250 to $400 per year ▪ Increased services available for out-of-state coverage through a defined network (PHCS) with over 725,000 physicians in 50 states ▪ Annual individual deductible and/or out-of-pocket maximum (if applicable) will be met when a family member has had enough healthcare expenses that he/she meets the individual deductible and/or out-of-pocket maximum. The plan will pay for the individual's expenses, but not the health care expenses of other family members until the family deductible is met
Prescription Plan	▪ Increased coverage for disease management: ✓ Long-lasting asthma medication (Advair and Symbicort) will be offered at a reduced rate ✓ Diabetic coverage for lancets and test strips will be offered at Tier 1 prescription rates; increase diabetic products obtained as durable medical equipment (DME) from 75% to 90% co-insurance
Dental Plan	▪ Delta Dental buy-up plan allows pro-rated orthodontia coverage if in active treatment on or after January 1, 2016
Flexible spending account	▪ Increase Medical Flexible Spending Account maximum contribution from $2,500 to $2,550

Who is Eligible for Coverage?

HonorHealth employees regularly scheduled to work a minimum of 32 hours per pay period (excluding per-diem) are eligible to enroll in any of the benefits described in this book. When you enroll, you may also enroll your eligible dependents (where applicable), including the following:

- Your spouse or domestic partner.
- Your dependent child(ren) under age 26 who are
    - your natural, adopted, stepchild(ren), child(ren) of your domestic partner or child under a legal guardianship order.
    - living with you or not living with you; and married or unmarried.
- Your disabled child (any age) if the disability began prior to age 26.

Important! If you enroll a new dependent (spouse or child) during Open Enrollment, you must provide proof of dependent status for that individual, such as a marriage license for your spouse and a birth certificate a child.

Can I waive/decline insurance coverage?

You may waive/decline insurance coverage during Open Enrollment. Use the Online Enrollment system through Staff Member Self Service to indicate which benefits you wish to waive/decline. Coverage will cease on December 31, 2015. There is no monetary compensation to you when you waive/decline any benefit.

What happens if I do nothing?

Your health, dental, vision, accident plan, critical illness and prepaid legal plans will continue as is. You must always re-enroll each year if you want a flexible spending account for health and/or day care expenses. Your current flex election(s) will not continue into 2016 unless you re-enroll.

How do I make my benefit elections for 2016?

All benefit elections and changes must be done online through Staff Member Self Service.
If you are not making any changes (including adding/dropping dependents) to health, dental, vision, accident plan, critical illness and the legal plan, then no action is required. Your coverage will remain the same and continue in 2016. Remember, you always need to re-enroll in a flexible spending account.

A reminder about Alex

Alex is HonorHealth's online benefits counselor. When you seek help from Alex, it's like having a virtual conversation with an expert, but without all the insurance jargon.

In our increasingly automated world, it's nice to know you can get information on exactly what you're looking for without having to sift through a lot of information that's not relevant to you.

Alex is more than a machine that dispenses information. It personalizes the conversation. How big is your family? Will everyone require coverage?

You have 24/7 access to an easy-to-understand counselor who can help you choose the benefits that are right for you - health, dental, vision, flex spending, voluntary benefits and more. Visit Alex at www.myalex.com/honorhealth/2016.

Health Plan Options

HonorHealth offers the choice of three health plans. All three plans offer you comprehensive coverage for medical and prescription drug expenses, as well as access to our own network of healthcare providers and facilities, which will be referred to in this guidebook as the HonorHealth Network.

HonorHealth Network is a growing network of primary care and specialty physicians that includes all HonorHealth hospitals and facilities. It also includes primary care physician practices, immediate care centers and an urgent care center. For a list of HonorHealth providers covered under the plan, go to http://shc.force.com/BenefitPlanProviders where you can search by physician last name, physician zip code or physician specialty.

You will also have access to the Blue Cross Blue Shield of Arizona (**BCBSAZ**) Network, but each plan differs in what services are covered by BCBSAZ. You will receive the highest level of benefits when you use the HonorHealth Network.

You have a choice between three health plan options:

- Coordinated Care Plan
- Standard Plan
- Health Savings Account Plan (HDHP) with a Health Savings Account

Please take some time to review the information in this section - you'll find a summary of each plan, a chart summarizing each plan option and your cost per pay period.

• Coordinated Care Plan

This health plan is popular with individuals and families who use in-network healthcare providers and who prefer to pay for services through co-pays or co-insurance payments.

Preventive health services are paid 100% when you use an HonorHealth provider.

You will pay lower co-pays and co-insurance when you use a primary care physician (which will continue to include BCBSAZ family practice pediatricians), specialist, or facility within the HonorHealth Network. You may visit a specialist from either network **without** a referral from your primary care physician.

The Coordinated Care Plan protects you from serious unforeseen financial costs with an annual out-of-pocket maximum. The Plan does **not include coverage for out-of-network providers**, except in the event of an illness/emergency.

• Standard Plan

This health plan offers individuals and families the flexibility to use both HonorHealth and BCBSAZ in-network providers and who prefer to pay for services through co-pays or co-insurance payments. Preventive health services are paid at 100% when you use an HonorHealth and a BCBSAZ provider.

You will pay lower co-pays and co-insurance when you use a primary care physician, specialist, or facility within the HonorHealth Network. You may visit a specialist from either network **without** a referral from your primary care physician.

The Standard Plan protects you from serious unforeseen financial costs with an annual out-of-pocket maximum. The plan does **not include coverage for out-of-network providers**, except in the event of an illness/emergency.

- # Health Savings Account Plan (HDHP) with a HSA

This health plan offers a wide range of coverage to individuals and families, including 100% coverage for preventive health services provided by an HonorHealth Network or BCBSAZ physician. The plan also features an out-of-pocket maximum to protect you from catastrophic financial loss.

The HSA Plan has an ***annual deductible*** ($2,600 for an individual and $5,200 for a family) that must first be satisfied before the plan pays for most healthcare services and prescription drug costs.

To help pay your annual deductible and out-of-pocket medical expenses, a special tax-advantaged **Health Savings Account (HSA)** is included in the plan. Contributions may be made to your HSA, and the money in your account may be used to pay for eligible medical, prescription drug, dental or vision expenses you incur.

How does the deductible work if I am covering my dependents?

If you are covering dependent(s) in 2016, you are **not required** to meet the family deductible first before the plan starts paying. Your individual deductible applies.

Adding money to your Health Savings Account

Each year HonorHealth will contribute/match up to $1,300 for individual coverage or $2,600 for family coverage to your HSA, provided you are also making contributions. The company contribution will be 100% of your contribution up to a per pay period (24 pay periods) maximum of $54.17 for individual and $108.33 for family. The IRS has established a maximum amount that may be contributed each year to your Health Savings Account. For 2016, the maximum amounts are $3,350 for individual and $6,750 for a family. If you are age 55 to 65 and not enrolled in Medicare, you may add an additional $1,000 catch-up contribution per year.

Your funds roll over and accumulate year to year if not spent. The money in your account may earn interest, and under certain circumstances may be invested according to the rules of the HSA provider. **All money in your HSA belongs to you.** Your money may be taken with you if you leave HonorHealth.

If you are considering a Health Savings Account

Although your HSA funds may grow from year to year, in the beginning, HonorHealth's contributions and your contributions together will possibly be less than your medical expenses. Unlike Flex Spending Accounts, you may spend only the amount that is accrued in your HSA account at the time you incur a medical expense. However, you may reimburse yourself later as your funds increase.

If you choose the Health Savings Account medical plan, you may also enroll in a Limited Purpose Healthcare Flexible Spending Account, but not the Health FSA. The Limited Purpose Healthcare FSA may be used for your dental and vision expenses.

The IRS has many rules governing Health Savings Accounts, so before you commit to this plan, be sure you understand who is eligible, how it's used, its limitations and how your tax status may be affected.

Summary of Benefits

The charts below provide a sample of frequently used medical services and the amount the plan pays. For a complete list of covered services, refer to the Summary Plan Description available on the employee website or Staff Member Self Service. You may also request a copy be mailed to your home address by contacting the Employee Benefits Department at 480-323-4667 or email employee.benefits@honorhealth.com.

Coordinated Care Plan Summary of Benefits

Health Plan Benefits	In-Network HonorHealth Providers	In-Network Blue Cross Blue Shield of Arizona	Out-of-Network
Annual Out-of-Pocket Maximum	$5,000 individual/$10,000 family		Unlimited
Primary Physician Office Visit (PCP, General Practitioner, Pediatric, Internal Medicine)	$10 co-pay (includes BCBSAZ family pediatricians), then plan pays 100%	Not covered	Not covered
Specialist Office Visit *BCBSAZ specialists in Rheumatology, Endocrinology and Pediatrics will be covered at a $40 co-pay	$30 co-pay, then plan pays 100%	$40 co-pay if specialty not in HonorHealth network*; otherwise $100 co-pay, then plan pays 100%	Not covered
Other Physician Services *BCBSAZ specialists in Rheumatology, Endocrinology, Pediatrics, Anesthesiology, Radiology, Pathology and Hospitalist will be covered at 90%	Plan pays 90%*	Plan pays 70%	Not covered
Preventive Care	Plan pays 100%	Not covered (except Pediatric)	Not covered
Hospital Services – Inpatient	$150 co-pay per day up to 5 days, then plan pays 100%	Not covered	Not covered
Urgent Care	$25 co-pay, then plan pays 100%	$25 co-pay, then plan pays 100%	Not covered
Outpatient Surgery Facility	$150 co-pay, then plan pays 100%	Not covered	Not covered
Outpatient Laboratory Services	$10 co-pay, then plan pays 100%	$10 co-pay, then plan pays 100%	Not covered
Physical & Occupational Therapy Calendar year maximum – 60 visits	$30 co-pay per visit, then plan pays 100%	$30 co-pay per visit, then plan pays 100%	Not covered
Outpatient Radiology (X-ray, Ultrasound)	$10 co-pay, then plan pays 100%	Plan pays 50%	Not covered
Outpatient Complex Radiology (MRI, MRA, CT, PET)	$100 co-pay, then plan pays 90%	Not covered	Not covered
Emergency Room	$250 co-pay, then plan pays 100%	$250 co-pay, then plan pays 100%	$250 co-pay, then plan pays 100%
Out-of-Area Services (traveling or living temporarily outside Arizona)	Plan pays defined rates for the type of covered service provided		

Standard Plan Summary of Benefits

Health Plan Benefits	In-Network HonorHealth Providers	In-Network Blue Cross Blue Shield of Arizona	Out-of-Network
Annual Out-of-Pocket Maximum	$6,450 individual $12,900 family		Unlimited except where stated
General Physician Office Visit (PCP, General Practitioner, Pediatric, Internal Medicine)	$20 co-pay, then plan pays 100%	$40 co-pay, then plan pays 100%	Not covered
Specialist Office Visit	$50 co-pay, then plan pays 100%	$60 co-pay if specialty not in HonorHealth network; otherwise $100 co-pay, then plan pays 100%	Not covered
Other Physician Services	Plan pays 85%	Plan pays 70%	Not covered
Preventive Care	Plan pays 100%	Plan pays 100%	Not covered
Hospital Services - Inpatient	$200 co-pay per day up to 5 days, then 100%	$400 co-pay per day for 5 days, then plan pays 50%	Not covered
Urgent Care Facility	$25 co-pay, then plan pays 100%	$25 co-pay, then plan pays 100%	Not covered
Outpatient Surgery Facility	$200 co-pay, then plan pays 100%	$400 co-pay, then plan pays 50%	Not covered
Outpatient Laboratory Services	$15 co-pay, then plan pays 100%	$15 co-pay, then plan pays 100%	Not covered
Outpatient Physical and Occupational Therapy Services Calendar year maximum – 60 visits	$30 co-pay per visit, then plan pays 100%	$30 co-pay per visit, then plan pays 100%	Not covered
Outpatient Radiology (X-ray, Ultrasound)	$15 co-pay, then plan pays 100%	Plan pays 75%	Not covered
Outpatient Complex Radiology (CT, MRI)	$150 co-pay, then plan pays 85%	$200 co-pay, then plan pays 50%	Not covered
Emergency Room	$300 co-pay, then plan pays 100%	$300 co-pay, then plan pays 100%	$300 co-pay, then plan pays 100%
Out-of-Area Services (while traveling or living temporarily outside Arizona)	Plan pays defined rates for the type of covered service provided		

Health Savings Account Plan (HDHP) Summary of Benefits

Health Plan Benefits	In-Network HonorHealth Providers	In-Network Blue Cross Blue Shield of Arizona	Out-of-Network
Health Savings Account contributions (only if employee contributes)	Employee Only - up to $1,300 per year Employee/Spouse/Child/Family - up to $2,600 per year		
Annual Deductible	$2,600 individual $5,200 family		$3,600 individual $7,200 family
Annual Out-of-Pocket Maximum	$6,450 individual $12,900 family		Unlimited except where stated
General Physician Office Visit (PCP, General Practitioner, Pediatric, Internal Medicine)	Plan pays 90%	Plan pays 80%	Not covered
Specialist Office Visit	Plan pays 90%	Plan pays 80%	Not covered
Other Physician Services	Plan pays 90%	Plan pays 70%	Not covered
Preventive Care (deductible waived)	Plan pays 100%	Plan pays 100%	Not covered
Hospital Services - Inpatient	Plan pays 90%	Plan pays 50%	Not covered
Urgent Care Facility	Plan pays 80%	Plan pays 80%	Not covered
Outpatient Surgery Facility	Plan pays 90%	Plan pays 50%	Not covered
Outpatient Laboratory Services	Plan pays 90%	Plan pays 90%	Not covered
Outpatient Physical and Occupational Therapy Services Calendar year maximum – 60 visits	Plan pays 80%	Plan pays 80%	Not covered
Outpatient Radiology (X-ray, Ultrasound)	Plan pays 90%	Plan pays 50%	Not covered
Outpatient Complex Radiology (CT, MRI)	Plan pays 90%	Plan pays 50%	Not covered
Emergency Room	Plan pays 80%	Plan pays 80%	Plan pays 80%
Out-of-Area Services (while traveling or living temporarily outside Arizona)	Plan pays defined rates for the type of covered service provided		

Prescription Drug Benefit

When you enroll in a health plan, prescription drug coverage is automatically included. EnvisionRX Options administers the prescription drug portion of your health plan. You'll need to fill your prescriptions at a participating pharmacy (close to 54,000 nationally), such as Avella, Civic Center Pharmacy, Fry's, Safeway, Walgreens and Wal-Mart. **CVS/pharmacy, Albertsons and Target pharmacies** are not part of the network. The following prescription drug coverage is included in each of the health plans:

Prescription Drug Benefit	Coordinated Care Plan	Standard Plan	Health Savings Account Plan
Deductible	None	None	$2,600 individual/$5,200 family
Generic maintenance medications only Limited to asthma, diabetes, cardiac, and hypertension medications	30-day supply: $0 co-pay 90-day supply: $0 co-pay	30-day supply: $5 co-pay 90-day supply: $15 copay	30-Day Supply: $5 co-pay 90-Day Supply: $15 co-pay
Tier 1: Generic drugs (Generic birth control pills covered 100% under all plans)	$4 co-pay 90-day supply: $10 co-pay	$15 co-pay 90-day supply: $37.50 co-pay	$7 co-pay 90-day supply: $17.50 co-pay
Tier 2: Formulary brand-name drugs	30-day supply: You pay 30% ($30 min. up to $80 max.)	30-day supply: You pay 35% ($40 min. up to $100 max.)	30-day supply: You pay 35% ($40 min. up to $100 max.)
	90-day supply: You pay 30% ($75 min. up to $200 max.)	90-day supply: You pay 35% (min. $100 up to $250 max.)	90-day supply: You pay 35% (min. $100 up to $250 max.)
Tier 3: Non-formulary brand-name drugs (30 day supply only)	You pay 60% ($100 min.; no maximum)	You pay 60% ($125 min.; no max.)	You pay 60% ($125 min.; no max.)
Specialty drugs through Avella pharmacy (30 day supply only)	You pay 30% ($50 min. up to $100 max.)	You pay 30% ($60 min. up to $150 max.)	You pay 30% ($60 min. up to $150 max.)
	A **Dispense as Written (DAW) Penalty** may be applied to your prescription cost if you fill a preferred or non-preferred drug that has an available generic version. You will pay the difference in cost between the two drugs along with the 20% or 50% co-insurance. Register at www.envisionrx.com to find your actual out-of-pocket cost for your preferred and non-preferred Brand medications.		

Preventive Health Care Services and Women's Preventive Services

Your health plans offer 100% coverage for the following preventive services only when the services are obtained from an HonorHealth in-network provider if covered under the Coordinated Care Plan. Under the Standard Plan and Health Savings Account Plan, services must be obtained from an HonorHealth in-network provider or Blue Cross Blue Shield of Arizona in-network provider:

- Well woman
- Well man
- Well child
- Immunizations
- Routine physical exam
- Pre- and post-natal visits
- Vasectomy
- Tubal ligation
- Generic birth control pills and other non-over-the-counter contraceptives that are FDA approved

Behavioral Health Services

Magellan Health provides in-network services and coordination of care for all behavioral health benefits within the health plans. You can obtain the behavioral health services you need in one of two ways:

Employee Assistance Program (EAP)

Make a confidential appointment with an HonorHealth EAP counselor by calling 480-882-4599. Counseling sessions are available to employees and immediate family members at no cost. Your EAP counselor will help you and your family identify and assesses your issues. In many cases just two or three visits with an EAP counselor will help you address the problem and return to a happier and more productive life.

If necessary, your EAP counselor will assist you in finding a well-qualified professional within the Magellan Health Network when you need additional behavioral health services. Your EAP counselor will remain available to provide other services if they become necessary.

Contact Magellan Health's Customer Service

Simply call Magellan Health at 800-424-4138. A Magellan Health customer service representative will answer your call and ask you some questions in order to serve you better. The representative can also answer questions you may have about your care.

The representative may transfer your call to a Magellan care manager for referral, preauthorization, or emergency services based upon your needs. Magellan care managers are skilled mental health and substance abuse experts who work as confidential advocates for you. Their purpose is to assess your situation and ensure that you or your family members receive the type of care required by your health plan.

Your Magellan care manager may refer you to a network provider if your problem needs mental health or substance abuse services. The care manager coordinates and guides all of your inpatient and/or outpatient mental health and substance abuse care.

Summary of Benefits – Behavioral Health Services

Behavioral Health Benefit	Coordinated Care Plan Magellan Health	Standard Plan Magellan Health	Health Savings Account Plan Magellan Health
Annual Deductible (Individual/Family) (combined with health plan)	None	None	$2,600 individual $5,200 family
Annual Out-of-Pocket Maximum (Individual/Family) (combined with health plan)	$5,000 individual $10,000 family	$6,450 individual $12,900 family	$6,450 individual $12,900 family
Outpatient Therapy with Social Worker (MSW) (group, individual, family and medication evaluation)	$20 co-pay, then plan pays 100%	$30 co-pay, then plan pays 100%	80%
Outpatient Therapy with PhD or MD (group, individual, family and medical evaluation)	$40 co-pay, then plan pays 100%	$60 co-pay, then plan pays 100%	80%
Intensive Outpatient	$30 co-pay, then plan pays 100%	$50 co-pay, then plan pays 100%	90%
Residential (prior authorization required)	$150 co-pay per day up to 5 days per admission, then plan pays 100%	$200 co-pay per day up to 5 days per admission, then plan pays 100%	90%
Inpatient & Partial Hospitalization/Emergency Admissions (prior authorization required)	$150 co-pay per day up to 5 days per admission, then plan pays 100%	$200 co-pay per day up to 5 days per admission, then plan pays 100%	90%

Teladoc

HonorHealth provides you and your covered family members enrolled in the health plan with a convenient online urgent care service. Teladoc offers 24/7 access to leading board certified physicians trained in emergency medicine.

Simply register online for the service at www.teladoc.com answer a few questions about your condition and set up an appointment. Within a few minutes, you will receive a call from an emergency room physician who can provide a personalized, timely and efficient consultation, diagnosis and treatment. Using your smart phone or computer, you can even have a virtual face-to-face video consultation through their video feed. When recommended, a prescription will be sent electronically to the pharmacy of your choice within the network.

Teladoc is not an advice line. Instead, it's like getting a virtual house call from a doctor. Long, frustrating waits in the emergency room and urgent care center can be avoided for most urgent medical conditions. Using Teladoc reduces the cost of care for both for you and for HonorHealth while providing on-demand care from a physician at your convenience.

If you are enrolled in the Coordinated Care Plan or Standard Plan: HonorHealth pays a portion of each visit for you. Your co-pay is only $25 each time you use the service.

If you are enrolled in the Health Savings Account Plan (HDHP): You will pay the full fee of $50 until your annual deductible is met. Thereafter, you will continue to pay the full fee, but the health plan will reimburse you for 50% of the fee each time you use this service.

Out-of-Pocket Maximum

An out-of-pocket maximum helps to protect you from catastrophic financial hardship if you experience a serious illness. This limit is the maximum amount of deductibles, co-pays and co-insurance you are responsible for paying each calendar year for most covered health plan services. Once you reach this limit, the plan pays 100% of the coinsurance for your covered expenses.

Although your plan may cover a portion of certain services you receive from out-of-network providers, covered expenses for out-of network providers do not accumulate to your plan's out-of-pocket max limit. Whenever possible, we recommend you seek in-network services to keep your expenses low. Expenses that are out-of-network do not accumulate towards the out-of-pocket max, may not be considered non-covered expenses, have a penalty for failing to pre-certify and may result in balance billing from providers.

Wellness Program

As an employee, you can voluntarily participate in our Wellness program. The mission of our program is to promote and improve the wellness of our entire population by empowering each employee to develop a lifestyle that includes health-promoting behaviors and regular preventive care.

The Wellness portal will help you improve and monitor your nutrition and physical activity, participate in wellness challenges all while earning points that can be applied to receiving an incentive discount towards **future** insurance premiums. It can be personalized by you, and it is entirely confidential. Enroll today and start working towards a healthier you at https://honorhealth.livepurewellness.com. For more information, please contact the Wellness team at wellness@honorhealth.com.

Dental Plans

HonorHealth offers two dental providers, Delta Dental and Employers Dental Services (EDS).

- **Delta Dental Buy Up Plan or the Base Plan.**

Both use the same Delta Dental provider networks, but with the Buy Up Plan, orthodontia and major services **are** covered.

With the Basic Plan, orthodontia and major services like crowns **are not** covered. To search for a Delta Dental provider, please visit www.deltadentalaz.com.

2015 Schedule of Dental Benefits

	Buy Up Plan		Base Plan	
	PPO Dentist	**Premier Dentist**	**PPO Dentist**	**Premier Dentist**
Maximum Annual Benefit	$2,000		$1,000	
Annual Deductible	$50/person	$150/family	$50/person	$150/family
Preventive Services (Includes two exams and cleanings per year)	100%	90%	100%	90%
Basic Care (Includes fillings, extractions, root canal)	80%*	70%*	80%*	70%*
Major Care (Includes inlays, onlays, bridges, dentures)	50%*		Not covered	
Orthodontia (pro-rated coverage if in active treatment plan on or after January 1, 2016)	50%		Not covered	
Lifetime Orthodontia Maximum	$2,000		N/A	

**Deductible applies to all benefits, unless otherwise noted.*

• **The Employers Dental Services (EDS) Plan.** This plan is an HMO plan. You must designate a primary dentist to oversee your care. To receive coverage, you and your covered dependents must visit a dental care provider that participates in the EDS network.

Service	Your Co-Pay*
Office Visit	$3
Oral Exam/Topical Fluoride Application	No Charge
Routine Cleaning	$3
Sealants (Per Tooth)	$11
Amalgam filling; one surface	$11
Crown (resin)	$450
Dentures, complete upper set	$555
Simple Extraction	$55

***These are just an example of a few popular services. Your actual co-pay is determined by the detailed service code(s) billed by the dentist, so your cost could be higher.**

There are no annual or lifetime maximum benefits or deductibles to meet before the plan begins to pay benefits.

If you elect this plan, EDS will assign a dentist to you based on your zip code. You'll be able to change dentists at a later date. To find a provider in the Employers Dental Services Plan, visit **https://www.mydentalplan.net/** using Plan 300N.

If You Have Treatment In Progress

If you elect the EDS plan, any in-process treatment you or your dependents are currently receiving, such as orthodontia-**is not covered.**

Your Medical and Dental Benefit Rates/Premiums

The following amounts will be deducted from your paycheck, pre-tax for the benefits you select.
Full-time rates apply if you work in a budgeted position of 60 hours or more per pay period.
Part-time rates apply if you work in a budgeted position of 32 to 59 hours per pay period.

Payroll Deductions Effective January 1, 2016

*Health Plans	Full-time	Part-time
Coordinated Care Plan		
Employee Only	$93	$151
Employee & Spouse/Partner	$200	$365
Employee & Child(ren)	$120	$205
Employee & Family	$240	$445
Standard Plan		
Employee Only	$162	$289
Employee & Spouse/Partner	$292	$549
Employee & Child(ren)	$167	$299
Employee & Family	$343	$651
Health Savings Account Plan		
Employee Only	$93	$151
Employee & Spouse/Partner	$200	$365
Employee & Child(ren)	$120	$205
Employee & Family	$240	$445

Tobacco Free Incentive – Deduct **$50** from the rate for being tobacco free.

Wellness Program Incentive – Deduct **$20** from the rate if you earned all 7 required points during the 2015 Wellness Program.

Tobacco Surcharge if covering a spouse/partner – Add **$50** per pay period if your covered spouse is a tobacco user or chose not to previously participate in testing.

Dental Plans	Full-time	Part-time
Delta Dental Buy-Up Plan		
Employee Only	$10.46	$15.69
Employee & Spouse/Partner	$26.44	$39.66
Employee & Child(ren)	$27.55	$41.32
Employee & Family	$49.16	$73.74
Delta Dental Base Plan		
Employee Only	$5.23	$7.85
Employee & Spouse/Partner	$13.22	$19.83
Employee & Child(ren)	$13.77	$20.65
Employee & Family	$24.58	$36.87
EDS Dental Plan		
Employee Only	$1.71	$2.56
Employee & Spouse/Partner	$3.69	$5.53
Employee & Child(ren)	$4.91	$7.36
Employee & Family	$5.72	$8.58

Vision Plans and Rates

HonorHealth offers two vision plans. Like the medical and dental plans, your vision plan offers in- and out-of-network benefits, but your dollar goes further when you use in-network providers. The two plans are Vision Service Plan (VSP) and UnitedHealthcare Vision.

Both plans offer a comprehensive eye exam every year for a small co-payment.

A summary of the vision benefits is shown in the charts below.

2016 Schedule of Vision Benefits

	Vision Service Plan		UnitedHealthcare	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Eye Exam	$10 co-pay	Plan pays up to $45	$10 co-pay	Plan pays up to $40
Frames	Plan pays up to $130 for most frames Plan pays up to $150 for featured frame brands 20% discount on amount over plan's allowance	Plan pays up to $70	Plan pays up to $130 Plan pays up to 20% discount on amount over plan's allowance	Plan pays up to $45
Single Vision Lenses	$30 Co-pay	Plan pays up to $30	$30 co-pay	Plan pays up to $40
Contact Lenses	Plan pays up to $130 for contacts instead of glasses; you pay up to a $60 co-pay	Plan pays up to $105	Plan pays up to $130 for contacts instead of glasses; $30 co-pay	Plan pays up to $105

Your Premiums per pay check	VSP	UnitedHealthcare
Employee Only	$3.15	$2.26
Employee & Spouse/Partner	$6.30	$4.20
Employee & Child(ren)	$6.75	$5.25
Employee & Family	$10.78	$7.34

Flexible Spending Accounts (FSAs)

If you have out-of-pocket medical expenses or if you pay for child care, you can save money by setting up a healthcare or dependent care Flexible Spending Account (FSA) that allows you to set aside funds to pay these expenses with before-tax dollars. That is, you do not pay taxes on the money that you put into your FSAs. Generally, taxes deducted from your paycheck are lower and your net monthly income is higher, so you get more out of your paycheck.

If you are enrolled in the Health Savings Account (HSA) health plan, *you are not eligible* to enroll in a healthcare Flex Savings account. Instead, you may enroll in the Limited Purpose FSA. However, you are not barred from enrolling in a Dependent Care Flex Spending Account.

The **Healthcare Spending Account** reimburses you for medical, dental and vision expenses, including medical and pharmacy co-payments and coinsurance as well as certain over-the-counter medications. You may contribute up to $2,550 in 2016 toward your Healthcare Spending Account.

The **Dependent Care Spending Account** allows you to pay for day care expenses for your dependent children or a disabled adult (whom you declare as a dependent on your federal tax return) while you work or look for work. You may contribute up to $5,000 in 2016 toward your Dependent Care Spending Account.

The two spending accounts are separate – you cannot be reimbursed for dependent care expenses from a Healthcare FSA, and vice versa

How Flex Plans Work

You decide how much money you and your family will spend on eligible healthcare and/or dependent day care expenses in 2016 (January 1 to December 31). This amount will be deducted, before taxes, in equal amounts from each of your paychecks during 2016. Since the money is set aside pre-tax, you save on federal, state, Social Security and Medicare taxes, and you keep more of your take-home pay.

The amounts that you specify will go into your Healthcare and/or Dependent Care Account(s). During the year, as you have eligible healthcare or dependent care expenses, you'll submit a claim and be reimbursed from your account with tax-free dollars.

If you have had a healthcare flex spending plan in the past, you should know that most over-the-counter (OTC) medications will not be reimbursable through your FSA **without a prescription or letter of medical necessity from your healthcare provider.** The IRS regulations, however, do allow normal reimbursement for ***certain*** categories of OTC medications, reading glasses and first aid items, to name just a few.

Be sure to estimate your 2016 expenses carefully. You will be allowed to carry-over up to $500 of your unused **Health Care Spending Account** money to spend for new expenses incurred in 2017, but it is important to know that any unused money in excess of $500 on January 1, 2017, will not carry-over and your will forfeit those dollars.

Critical Illness Insurance and Accident Insurance

If serious illness strikes, the last thing you need to worry about is how to pay the bills: copayments, car payments, rent or mortgage, utilities and food. That's why this insurance provides cash to help with the extra expenses associated with your recovery.

With **Critical Illness** insurance, if you are diagnosed with a covered illness, you get a lump-sum cash benefit to use however you wish—even if you receive benefits from other insurance.

The **Accident Plan** helps you handle the medical and out-of-pocket costs that add up after an accidental injury. This includes emergency treatment, hospital stays and medical exams, and other expenses you may face.

Critical Illness rates per pay period:

Age	Employee $10,000	Employee $20,000	Employee & Spouse/partner $10,000	Employee & Spouse/partner $20,000	Employee & Children $10,000	Employee & Children $20,000	Employee & Family $10,000	Employee & Family $20,000
<25	$0.50	$1.00	$0.80	$1.60	$0.80	$1.60	$1.10	$2.20
25-29	$0.60	$1.20	$1.00	$2.00	$0.90	$1.80	$1.30	$2.60
30-34	$1.00	$2.00	$1.70	$3.40	$1.30	$2.60	$2.00	$4.00
35-39	$1.70	$3.40	$2.80	$5.60	$2.00	$4.00	$3.10	$6.20
40-44	$3.10	$6.20	$5.20	$10.40	$3.40	$6.80	$5.50	$11.00
45-49	$5.50	$11.00	$9.30	$18.60	$5.80	$11.60	$9.60	$19.20
50-54	$8.50	$17.00	$14.70	$29.40	$8.80	$17.60	$15.00	$30.00
55-59	$12.80	$25.60	$22.90	$45.80	$13.10	$26.20	$23.20	$46.40
60-64	$18.90	$37.80	$34.50	$69.00	$19.20	$38.40	$34.80	$69.60
65-69	$28.00	$56.00	$52.20	$104.40	$28.30	$56.60	$52.50	$105.00
70-74	$41.00	$82.00	$75.80	$151.60	$41.30	$82.60	$76.10	$152.20
75-79	$59.80	$119.60	$108.20	$216.40	$60.10	$120.20	$108.50	$217.00
80-84	$76.50	$153.00	$136.50	$273.00	$76.80	$153.60	$136.80	$273.60
85+	$82.90	$165.80	$147.00	$294.00	$83.20	$166.40	$147.30	$294.60

Accident Plan rates per pay period:

Employee Only	Employee & Spouse/partner	Employee & Children	Employee & Family
$6.14	$9.16	$11.59	$14.81

Prepaid Legal Services

MetLife Legal Plans is your provider for prepaid legal and financial services. Through the MetLaw program, you can receive telephone and office consultations for a variety of matters with any MetLaw attorney. Legal representation includes such matters as:

- Estate planning and other financial issues.
- Real estate advice.
- Family law.
- Traffic offenses.
- Consumer protection.
- Juvenile matters.
- Legal document preparation and review.

Once you have enrolled, you may also enroll your parents at a discounted price. The Family Matters Plan offers your parents the same estate planning and legal services with no waiting period, deductibles, co-payments or claim forms. For additional information on this feature, contact MetLife Legal Plans' Client Service Center at 800-821-6400.

Once enrolled, you may cancel the MetLife Legal Plan at any time after you have completed one year of coverage.

The per pay period cost for the legal plan is $9.50.

Important Plan Information

Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 require health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information. This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You can obtain a copy of this Notice from the Employee Benefits Department.

Patient Protection Rights of the Affordable Care Act

The medical plans offered by HonorHealth do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or out-of-network health care provider; however, payment by the Plan may be less or not covered at all for the use of an out-of-network provider. You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Employee Benefits Department at 480-323-4667 or email at employee.benefits@honorhealth.com

Availability of Summary Health Information: the Summary of Benefit and Coverage (SBC) Documents

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instruction the Plan ad to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages, 2-sided), the font size, the colors used when printing the SBC and even which words were to be bold and underlines.

To get a free copy of the most current SBC documents for our medical plan options, go to Staff Member Self Service, or contact the Benefits Department at 480-323-4667.

Special Enrollment and Mid-Year Changes

Changes to Your Elections: You will not be allowed to change your benefits or add/delete dependents until the Open Enrollment period for the next plan year (starting January 1) unless you experience a special enrollment event or a mid-year qualifying status changes.

Health Plan Special Enrollment Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment in writing within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

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

You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollments within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or to obtain more information, contact your Benefits Representative.

Mid-Year Change in Status Event:

Because our Plan pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a QMCSO.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within 30 days of the mid-year change in status event by contacting the Employee Benefits Department at 480-323-4667 or email at employee.benefits@honorhealth.com. The Plan will determine if your change request is permitted and if so, changes become effective immediately upon notification (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

COBRA Coverage

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See https://www.healthcare.gov. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce, or a child ceasing to be an eligible dependent child. The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce or a child ceasing to be a dependent child under the plan, you and/or your family member must inform the plan in writing of that event no later than 60 days after that event occurs. That notice should be sent to the Employee Benefits Department via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). If you have questions about COBRA, contact the Employee Benefits Department at 480-323-4667 or email employee.benefits@honorhealth.com.

Women's Health and Cancer Rights Act (WHCRA)

The medical plan options sponsored by HonorHealth comply with the Women's Health and Cancer Rights Act (HWCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

This coverage is subject to any plan copayments, referral requirements, annual deductibles and co-insurance provisions that may be applicable, consistent with those established for their benefits under the plan. These provisions are described in the Plan's Summary Plan Description (SPD). If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact Employee Benefits Department at 480- 323-4667 or email employee.benefits@honorhealth.com.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 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

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, you need to understand whether the prescription drug coverage that you elect from HonorHealth is or is not creditable with Medicare. Read the notice below.

This notice is for people with Medicare or people who will become eligible for Medicare in the next 12 months. Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with HonorHealth and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.
- If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

HonorHealth has determined that the Prescription Drug Plan within the Premium Partners Plan and the Health Savings Account Plan as administered by EnvisionRx Options, under the Health Plan is "creditable".

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan option(s) noted above is, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect to keep prescription drug coverage under the Prescription Drug Plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

IMPORTANT NOTE:

If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) **you and your employer may not continue to make contributions to your HSA once you are enrolled in Medicare**, including being enrolled in a Medicare Part D drug plan. So carefully consider whether it makes sense for you to enroll in the HDHP and also enroll in a Medicare Part D plan.

Remember To Keep This 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).

When Can You Join A Medicare Drug Plan?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

Why Creditable Coverage Is Important (When You Will Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-**

creditable prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's 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 either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

What Are My Choices? You can choose any one of the following options:

Your Choices:	**What you can do:**	**What this option means to you:**
Option 1	You can select or keep your current medical and prescription drug coverage with the Prescription Drug Plan, and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the Prescription Drug Plan. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15-December 7 of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can select or keep your current medical and prescription drug coverage with the Prescription Drug Plan **and also enroll in a Medicare prescription drug plan**. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under this Prescription Drug Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services. IMPORTANT: If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) **you and your employer may not continue to make contributions to your HSA once you are enrolled in Medicare**, including being enrolled in a Medicare Part D drug plan. So carefully consider whether it makes sense for you to enroll in the HDHP and also enroll in a Medicare Part D plan.

For More Information about Your Options under Medicare's Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

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

Para mas información sobre sus opciones bajo la cobertura de Medicare para recetas medicas.

Revise el manual "Medicare Y Used" para información detallada sobre los planes de Medicare que ofrecen cobertura para recetas medicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben de llamar al 1-877-486-2048. Para mas información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

As in all cases, HonorHealth reserves the right to modify benefits at any time, in accordance with applicable law.
This document is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.