Benefits

Enrollment Guide 2021

SCHOOL CITY OF MISHAWAKA

SAINT JOSEPH HEALTH SYSTEM
ACCOUNTABLE CARE ORGANIZATION

Administered by:
Auxiant
Independent Solutions › Real Results

Introduction

WHO IS ELIGIBLE?

If you're a full-time employee at School City of Mishawaka, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical, dental and vision coverage:

- Family Members
- Children up to the age of 26
- Spouse can only participate in Medical if they are not offered Insurance through their own job, but they can participate in dental and vision.

NEW HIRES, WHEN ARE YOU ELIGIBLE?

New employees are eligible for benefits on the first day of the month, following the beginning of full-time employment.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You are responsible for notifying Human Resources of any changes within 30 days of a qualified event. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan
- Losing existing health coverage
- Losing eligibility for Medicare, Medicaid, or CHIP
- Change in your income that affect the coverage you qualify for
- Losing COBRA coverage
- Losing coverage through a family member

Definitions

Annual Deductible—The amount you pay first before the plan begins paying expenses for covered services.

Coinsurance—The percentage you pay out-of-pocket after you have met the annual deductible.

Out-of-Pocket Maximum (Stop-Loss)—The maximum amount you pay each year in coinsurance for covered services.

Participating Provider—Physician or facility which is contracted with the Preferred Provider Network.

In-Network and Out-of-Network Benefits—In-network benefits are applied when services are rendered by a Participating Provider. Out-of-network benefits are applied when services are rendered by a Non-Participating Provider.

Reasonable & Customary (R&C)—A payment rate based on the fees for medical services charged by health care providers in a specified area (usually a zip code or group of related zip codes). Covered services are paid at R&C when the services are rendered by a Non-Participating Provider.

Balance Billing—Provider practice of billing the patient for the difference (or balance) of charges above the amount reimbursed by the health plan. Preferred Provider Plans prohibit participating providers from balance billing except for allowed copays, coinsurance and deductibles.

Contact Information for Benefit Vendors

Medical Insurance
Auxiant Health
800-475-2232
www.auxiant.com

Network
Select Health Network
800-263-2656
www.selecthealthnetwork.com

Telemedicine
TelaDoc
800-835-2362
www.teladoc.com

Midwest Behavioral Network
New Avenues
800-223-6246
www.newavenuesonline.com

Dental
Paramount Dental
800-727-1444
www.insuringsmiles.com

Vision
Vision Service Plans (VSP)
800-877-7195
www.vsp.com

School City of Mishawaka
Jenny Sanders
Benefits Specialist/Human Resources
(574) 254-4504
Email: sandersj@mishawaka.k12.in.us

R & R Benefits/Risk Management LLC
Troy Scott
CEO/General Counsel
Office: (574) 968-3654
Cell: (574) 596-7359
Troy.scott@randrbenefits.com
Email: www.randrbenefits.com

R & R Benefits/Risk Management LLC
Bob Frick
CFO
Office: (574) 968-3654
Cell: (574) 596-1785
Bob.frick@randrbenefits.com

Primary Care Physician Requirement

All School City of Mishawaka employees and dependents must choose a Select Health Network (SHN) Primary Care Physician (PCP).

- o Employee must include all chosen PCP(s) on the enrollment form.

Employees, covered spouses, college students and retirees living out of the area (30+ miles) will not have to choose a SHN PCP.

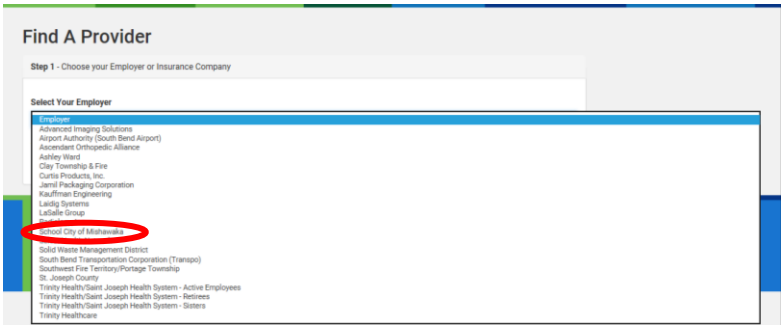
- o These “out of area” members must be identified on the enrollment form.

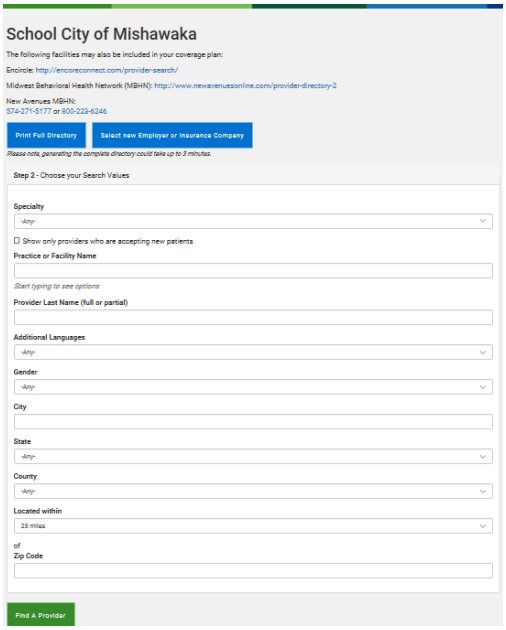
How to Find a Primary Care Physician

Always go to www.selecthealthnetwork.com when searching for an In-Network Tier 1 provider.

Step 1: On the homepage, click **Find Provider**

Step 2: Choose the **School City of Mishawaka** link





Step 3: Enter as many filters as desired,

then click **Find A Provider**

Questions? Please call 800.263.2656 or email findaprovider@selecthn.com

Networks

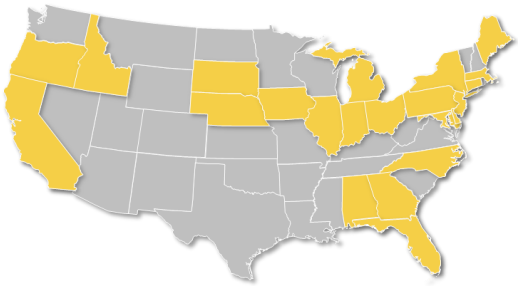
Your Provider Networks

Tier 1

The **Select Health Network** is your primary medical provider network (Tier 1) and serves as the medical home for members who reside in St. Joseph and Marshall Counties. The network consists of 3 Hospitals and over 750 Providers, including 150 Primary Care Physicians.

Trinity Health is a Catholic health care delivery system with providers in 22 States. The system includes 60 Hospitals and 5,900 providers. **Where available, School City of Mishawaka members may access the Trinity Health System at a Tier 1 Benefit level.**

Trinity Health Provider Network Map

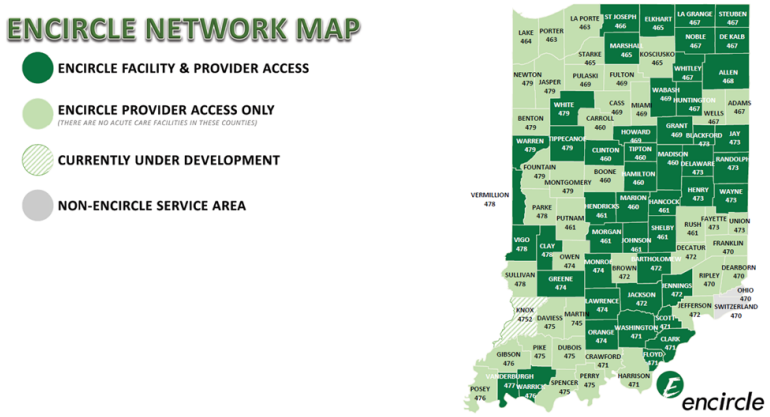


Tier 2

When services are not available within the Select Health Network, members may access the **Encircle Provider Network** at the same Tier 1 benefit level so long as an Approved Referral is obtained prior to receiving the service. You Primary Care Physician should call Auxiant Health to submit the referral. If a referral is not ob-tained, the member's benefits will be reduced by 30% for the services provided by the Encircle Network.

Encircle is an Indiana Statewide network including 105 hospitals and over 71,000 providers.

Encircle Provider Network Map



Tier 3

Members may receive services from any provider not part of the Tier 1 and Tier 2 Provider Networks at a Tier 3 Out-of-Network Benefit level.

If Urgent or Emergency Care services are needed when traveling outside of the State of Indiana, these services will also be covered at a Tier 1 benefit level. Members are encouraged to use a Private Healthcare Systems (PHCS) network provider for Tier 3 services.

Utilization Review and Precertification

Utilization review is the process of evaluating if services, supplies or treatment are medically necessary and appropriate to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the covered person and the Plan. Certification of medical necessity and appropriateness by the Utilization Review Organization does not establish eligibility under the Plan nor guarantee benefits.

The Plan requires precertification of certain services, supplies or treatment, as specified below. Under this Plan's claim filing procedures, the precertification call is considered to be filing a pre-service claim for benefits. Please see Claim Filing Procedures for details regarding a covered person's rights regarding pre-service claim determinations and appeals.

PRECERTIFICATION

The following list of services, treatments, admissions or procedures are to be certified in advance (precertification) by the Utilization Review Organization, except for emergencies. The covered person or their representative should call the Utilization Review Organization prior to the service, admission, procedure or treatment. Failure to pre-certify a *covered expense* will result in a 30% reduction of benefits.

Admissions
- All Inpatient (including obstetrics which exceed
- 48 hours for a vaginal delivery, and 96 hours
- following a cesarean section)
- Sub-Acute
- Long-term acute Rehabilitation Skilled Nursing

Applied Behavioral Analysis (ABA Therapy)

Behavioral Health
- Inpatient for Mental Health/Substance Abuse
- Residential Treatment (RES) for Mental Health/Substance
- Abuse
- Intensive Outpatient Program (IOP) for Mental Health/Substance Abuse
- Partial Hospitalization Program (PHP) for Mental
- Health/Substance Abuse

Dialysis Services

Durable Medical Equipment and Supplies
- Any purchase over $750All rentals

Enteral Feedings

Genetic Testing

Home Health Agency Services

Hospice

Implantable Devices
- Cardiac Defibrillators Cardiac Pacemakers

MRA Scan

MRI Scan

Obesity to include
- Bariatric Services
- Morbid Obesity Services

Occupational Therapy
- PA not required for evaluation and first 12 treatments)

Oncology Services
- Chemotherapy
- Radiation

Orthognathic Surgery

Pain Management Services including but not limited to
- PA required for >3 injections in 12-month period
- Epidural Steroid injections

PET Scans

Physical Therapy
- PA not required for evaluation and first 12 treatments

Plastic Surgery Procedures including but not limited to
- Abdominoplasty
- Blepharoplasty
- Mammoplasty
- Septoplasty Sclerotherapy
- Skin Lesion Removal
- Rhinoplasty

Prosthetic Devices
- Any purchase over $750
- All rentals

Specialty Pharmaceuticals

Speech Therapy
- PA not required for evaluation and first 12 treatments

Transplant Evaluations and Procedures
- Bone Marrow
- Organ

Contact Auxiant Health by calling:

800-475-2232

Benefit Tier Summary

Level	Network	Provider Referral Requirement	Prior Authorization Requirement See Prior Authorization List	Description
Tier 1	Select Health Network & Trinity Health	**No**	**Yes** All services listed on the current Prior Authorization List must be approved prior to delivery of care to be eligible for payment on your health plan	Pays according to Plan Document if prior authorization was obtained. If prior authorization was not obtained, member will incur a 30% reduction in benefits according to the Plan Document. This penalty does not apply to the deductible or maximum out of pocket.
Tier 2	Encircle	**Yes** A Select Health Network provider must submit a referral request for a member to see a Tier 2 Encircle provider	**Yes** All services listed on the current Prior Authorization List must be approved prior to delivery of care to be eligible for payment on your health plan	Pays according to Plan Document if referral and/or prior authorization was obtained. If a referral and/or prior authorization was not obtained, member will incur a 30% reduction in benefits according to the Plan Document. This penalty does not apply to the deductible or maximum out of pocket.
Tier 3	Out-of-Network	**No**	**Yes** All services listed on the current Prior Authorization List must be approved prior to delivery of care to be eligible for payment on your health plan	If prior authorization was obtained, services will pay according to Plan Document. If prior authorization was not obtained, member will incur a 30% reduction in benefits according to the Plan Document. This penalty does not apply to the deductible or maximum out of pocket.
Emergency Care	Encircle or Out-of-Network	No	No	Member or family member must notify the health plan within 72 hours of an emergency room visit or admission at an Encircle or Out-of-Network facility. NOTE – A transfer to an In-Network facility may be required once the member is deemed stable to transfer.

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HEALTH INSURANCE OVERVIEW 2021

The following chart details your health benefits that will take effect January 1, 2021.

	Network		
Services	Select Health Network & Trinity Health Tier 1	Encircle Network Tier 2	Out-of-Network Tier 3
Annual Deductible - Individual	$750	$750	$2,000
Annual Deductible – Family	$1,500	$1,500	$4,000
Annual Out-of-Pocket Maximum - Individual	$2,000	$2,000	$5,000
Annual Out-of-Pocket Maximum - Family	$4,000	$4,000	$10,000
Coinsurance	10%	10%	50%
Primary Care Physicians Office Visit	$20	$20	Deductible & 50%
Specialist Physician Office Visit	$40	$40	Deductible & 50%
Telemedicine Visit	$0	$0	Not Covered
Preventive Health Benefits	$0	$0	Not Covered
Urgent Care Center Services	$40	$40	Deductible & 50%
Hospital Inpatient Services	Deductible & 10%	Deductible & 10%	Deductible & 50%
Hospital Outpatient Services	Deductible & 10%	Deductible & 10%	Deductible & 50%
Emergency Room	$250	$250	$250
Prescription Drugs	**Provided through**	**CVS-Caremark**	
Prescription Drug Annual Deductible	No Deductible	No Deductible	$100
Retail Generic	$10	$10	Deductible & 50%

Retail Brand Formulary	$30	$30	Deductible & 50%
Retail Brand Non-Formulary	$50	$50	Deductible & 50%
Mail Order Generic	$15	$15	Not Covered
Mail Order Brand Formulary	$45	$45	Not Covered
Mail Order Brand Non-Formulary	$60	$60	Not Covered

**All members must select a Primary Care Physician from the Select Health Network. If no PCP is selected, a PCP accepting new patients will be assigned to the member. This PCP assignment may be changed at a later date. **

Value Based Insurance Design Program (VBID)

The St. Joseph Health System Accountable Care Organization is proud to offer the School City of Mishawaka health plan enrollees a VBID program designed to engage and improve health of members with Diabetes and Coronary Artery Disease (CAD). Members identified with Diabetes or CAD will be invited to participate in a chronic condition management program, where health coaches will assist members with self-management and coordination of care. Members who actively engage in the program, as determined by the health coach, will be eligible for the following benefits enhancements.

Waive copays for Primary Care Office Visits related to Chronic Condition Management.

Waive copays, deductible, and coinsurance for related lab service

For diabetic members, waive copays, deductibles, and coinsurance for Insulin, Insulin pumps, diabetic supplies, and hyperlipidemia and hypertension medications.

For CAD members, waive copays for diuretic, hyperlipidemia, hypertension, and beta body blocker medications.

Annual Wellness Screening

The St. Joseph's Health System Accountable Care Organization will offer all SCM health plan enrollees and their spouses the opportunity to participate in an annual wellness screening. This screening will consist of a Health Risk Assessment Questionnaire (HRA) and a biometric screening. If both the Employee and their spouse, as applicable, elect to participate in the wellness screening the employee's health plan premium contribution will be reduced by $150/single and up to $300/family the following year.

Note: This is only a brief description available under the plans. For a more detailed description of coverages, benefits, limitations and exclusions, please refer to the summary plan description.

Saint Joseph Health System Comprehensive Preventive Health Benefits

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These benefits are fully compliant with the Affordable Care Act (PPACA).

Wellness Exam:

Men - One per year

Women - One per year with family physician, one per year with OB/GYN, if needed

Childhood Immunizations

Vaccine	AGE>	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	7-10 years	11-12 years	13-18 years	16-18 years
Diphtheria, Tetanus, Pertussis				DTap	DTap	DTap		DTap				DTap		Tdap		
Human Papillomavirus														HPV 3 Doses		
Meningococcal ACWY														1 dose		1 dose
Influenza						Influenza (yearly)										
Pneumococcal				PCV	PCV	PCV	PCV				PPSV					
Hepatitis A							Hep A 2 Doses				Hep A Series					
Hepatitis B		Hep B	Hep B			Hep B							Hep B Series			
Inactivated Poliovirus				IPV	IPV	IPV						IPV				
Measles, Mumps, Rubella							MMR					MMR				
Varicella*							Varicella					Varicella				
Rotavirus				RV	RV	RV										
Haemophilus Influenzae Type B				HIB	HIB	HIB	HIB									
Meningococcal B																MenB 2 Doses

*Varicella expanded for 2nd dose to ages 18 and over.

Services for Children and Adolescents

• Gonorrhea preventative medication for eyes • Hearing Screening • Hemoglobinopathies (sickle cell) • Congenital Hypothyroidism • Phenylketonuria (PKU)	Newborns	Developmental/ Behavioral Assessment/Autism	All Ages
Fluoride Supplement	Children without fluoride in water source	Hematocrit or Hemoglobin Screening	All Ages
Iron Screening and Supplementation	All Ages	Lead Screening	For children at risk of exposure
HIV Screening	Age 15 and above	Screening for latent tuberculosis infection	Children determined at risk
Visual Acuity Screening	Up to age 5	Dyslipidemia Screening	All Ages
Oral Dental Screening	During PHB visit	Height, Weight and Body Mass Index measurements	All Ages
Urinalysis	All Ages	Medical History	All children throughout development
Depression Screening	Ages 12 to 18 years	COVID-19 Test	Per Clinician
Education & Counseling for prevention of Tobacco Use	School-Aged Adolescents		

Services for Pregnant Women

Aspirin	For Those At Risk
HIV Screening	1 per Pregnancy
Bacteriuria	Lab test
Hepatitis B	Lab test
Iron Deficiency Anemia Screening	Lab test
Gestational Diabetes Screening (between 24 & 28 weeks)	Lab test
Rh Incompatibility	Lab test
Syphilis Screening	Lab test
Chlamydia Screening	Lab test
Gonorrhea Screening	Lab test
Breast Feeding Interventions	Counseling, Support & Supplies
Tobacco and/ or Nicotine	Screening & Counseling
Folic Acid	Women capable of becoming pregnant
Referral to Counseling Intervention	For pregnant and postpartum at risk for perinatal depression
Tdap Vaccination	1 per pregnancy
Group B Strep Screening	1 per pregnancy

Services for All Women

Domestic Violence Screening & Counseling	Annually
Contraceptive Methods	Covered unless religious exemption applies
Age 21+, HPV DNA testing and/or cervical cytology	Every 3 years
BRCA Risk Assessment and Appropriate Genetic Counseling/Testing	

Adult Immunizations	
Tetanus, Diphtheria, Pertussis	Tdap once, then Td booster every 10 years after age 18
Human Papillomavirus	Women and Men to age 45
Meningococcal	2 doses ages 19+
Influenza	Every year
Pneumococcal*	Age 19-64: 1 PPSV23 dose + 1 PCV13 dose Age 65+: 1 PPSV23 dose + 1 PCV13 dose
Hepatitis A	2 to 3 doses/lifetime
Hepatitis B	3 doses/lifetime
Shingles*	Shingrix: 2 doses after age 50 Zostavax: 1 dose after age 50
Measles, Mumps and Rubella	Once after age 19 (up to two vaccinations per lifetime)
Varicella	2 doses to age 65
Meningococcal B	2 doses, if not done between ages 16-18

Adult Procedures/Services	
Bone Density Scan	Every 2 years age 60 or older
Mammogram - including 3D	Baseline - women, once between ages 35-39
Mammogram - including 3D	Yearly for women over 40
BRCA (letter of medical necessity required)	Women genetically at high risk of breast cancer
Sigmoidoscopy	Every 3 years after age 50
Colonoscopy	Every 10 years after age 50
Abdominal Aortic Aneurysm Screening	For men who have smoked - one time between ages 65-75
Low Dose Aspirin	At risk initiate treatment ages 50-59
Lung Cancer Screening	At risk Ages 55-80
Statin Preventative Medication	At risk Ages 40-75

Adult Labs	
Lipid Panel	As recommended by your physician
Total Serum Cholesterol	As recommended by your physician
PSA-Prostate Specific Antigen	Yearly for men age 50+
Fecal Occult Testing	Yearly after age 50
Highly Sensitive Fecal Occult Blood Testing	Every three years after age 50
FBS (Fasting Blood Sugar)	As recommended by your physician
Hgb A1C	As recommended by your physician
HIV Testing	Yearly after age 15
Syphilis Screening	At risk
Chlamydia Infection Screening	Yearly - All ages
Gonorrhea Screening	Yearly - All ages
Hepatitis B & Hepatitis C Screenings	Yearly
Urinalysis	Yearly
Screening for latent tuberculosis infection	At risk
CBC - Comprehensive Blood Count	As recommended by your physician
CMP - Comprehensive Metabolic Panel	As recommended by your physician
TSH - Thyroid Stimulating Hormone	As recommended by your physician
COVID-19 Test	Per Clinician

*This means adult patients may get as many as 2 doses of PPSV23 and 2 doses of PCV13

It is recommended that a preventive health visit include screenings and counseling for:	
Healthy Diet	Intimate Partner Violence for Men and Women
Obesity	Alcohol Misuse
Tobacco Use & FDA Approved Medication	Sexually Transmitted Infections
Blood Pressure	Depression
Skin Cancer Prevention	Developmental/Behavioral Assessment/Autism
Breast Cancer Chemoprevention for Women at High Risk	Fall Risk

The **Preventive Health Benefit Guidelines** are developed and periodically reviewed by our Quality Management Committee, a group of local physicians and health care providers. The QMC reviews routine care services from the American Academy of Family Practice Standards, American College of OB/GYN Standards, Center for Disease Control Recommendations, American Cancer Society Recommendations, American Academy of Pediatric Standards and U.S. Preventive Services Task Force Recommendations.

These recommendations were combined with input from local physicians and the standard Preventive Health Benefit was developed. These standards and recommendations are reviewed every one to two years, and the benefits are updated as needed.

Please note that your physician may recommend additional tests or screenings not included in this benefit. If you receive routine screenings that are not listed in this brochure you may have financial responsibility for those charges.

A screening procedure performed when there is a family history or personal history of a condition (and which does not fall within the listed age/frequency criteria of the Preventive Health Benefit) will be covered under the major medical benefit.

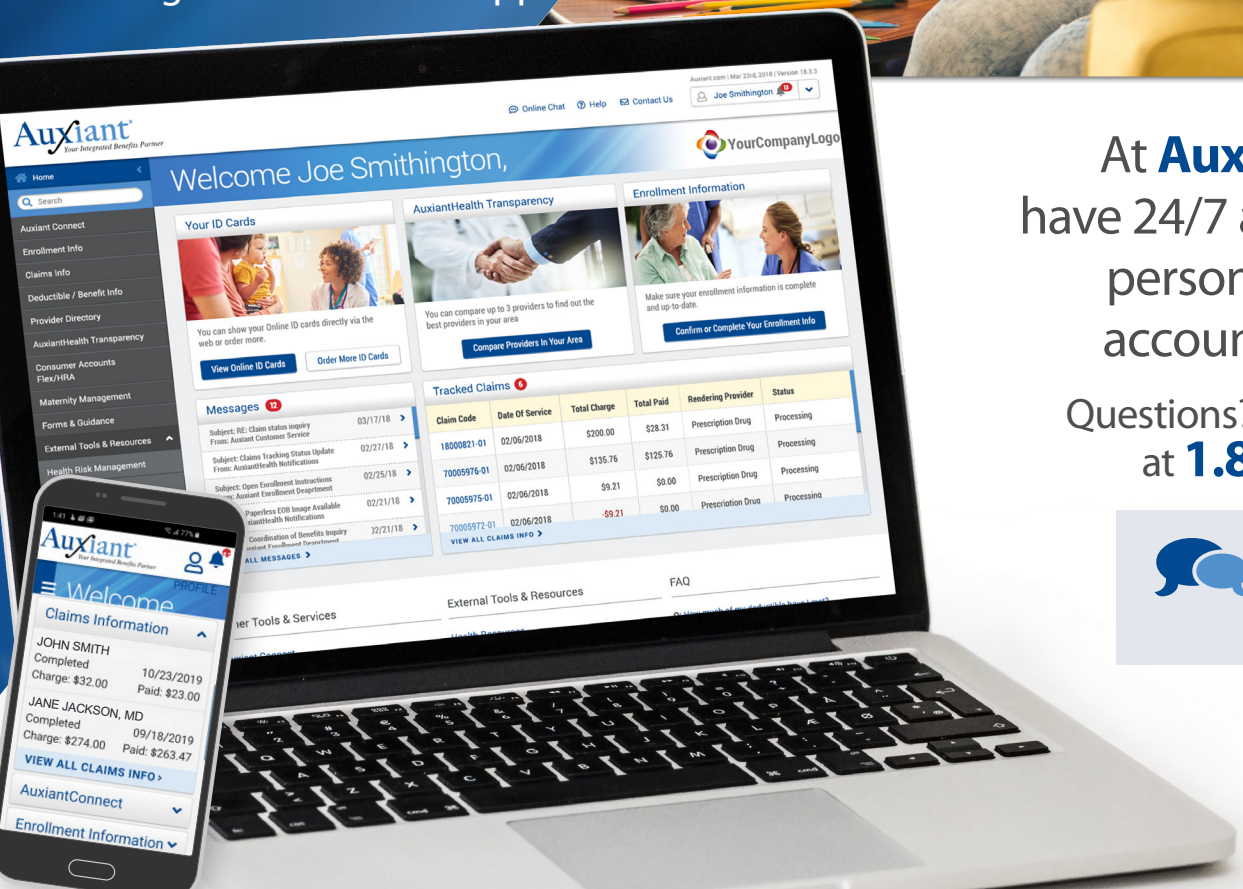
*Please contact Auxiant Health at 800.475.2232 for specific coverage information.

AuxiantHealth

VISIT US ON THE WEB
auxiant.com

With AuxiantHealth you can:

- Link to network providers
- Contact customer service through Auxiant Live Chat
- View enrollment and claim information, print EOB's, and track claims
- View deductibles and out-of-pocket amounts
- Access plan documents and amendments
- Link to Prescription Benefit Manager
- Get information on the go via our mobile app



At **Auxiant.com** you have 24/7 access to your personal health care account information

Questions? Contact Auxiant at **1.800.475.2232**

Live chat with Auxiant customer service, click **Online Chat** to begin

Auxiant®
Your Integrated Benefits Partner

UNDERSTANDING YOUR SCM HEALTH CARE PLAN

HELPFUL TIPS

Dependents living outside of the Select service area must have their out of area address listed with Auxiant in order to ensure proper claim payment. Please provide the out of area address to SCM.

SCM requires several services, admissions or procedures to be pre-certified in advance by Auxiant (except emergencies). The covered person or their representative should call Auxiant prior to the services. Failure to pre-certify a covered expense will result in a 30% reduction of benefits. Please refer to the Summary Plan Document (SPD) for a listing of services which require pre-certification.

Many services are covered under preventive care, including annual physicals, screening colonoscopies, and some immunizations. For a comprehensive list of services covered under preventive care, please refer to the benefits section of the SCM website.

For employer assistance program (EAP) information, please visit the SCM website or call Jenny Sanders at 574.254.4504.

WHAT YOU PAY

COPAYS

- Some types of service, including visits to a doctor's office, urgent care, and an emergency room have a copay.
- Copays range from $20 for a visit with your primary care physician to $250 for an emergency room visit for a true emergency.

DEDUCTIBLE

- This is the amount you must pay before your insurance starts paying.
- Some items are covered by insurance before you meet the deductible, including visits with a copay and preventive care.
- SCM's in network deductible is $750 individual/$1,500 family.

OUT OF POCKET MAXIMUM

- This is the maximum amount you could pay in a year for covered services.
- Once you have met your deductible, you will pay a coinsurance on most covered services until you meet your out of pocket max.
- SCM's in network out of pocket max is $2,000 individual/$4,000 family.

SCM PROVIDER NETWORK

- When looking for a provider always start with the Select Health Network. All services provided by a Select physician will be covered at the tier 1 cost.
- Encircle is your tier 2 network. Services provided by an Encircle provider will be covered at the tier 1 cost if you have a referral from a Select physician. Failure to obtain a referral will result in a 30% reduction in payment for coverage.
- Midwest Behavioral Health (New Avenues) is School City's behavioral health network. When looking for a psychiatrist, counselor, or facility in network, please choose a provider in the New Avenues network.

FINDING A PROVIDER

- You can access all three provider networks through selecthealthnetwork.com
- On the provider search page you will find a link for both Encircle and Midwest Behavioral Health located at the top of the page.
- When on the Encircle Network page, you must select which network SCM uses. Make sure you select the symbol that only says Encircle.
- If you need assistance locating a network provider call Select at 1.800.263.2656.

TELADOC™

Getting started with Teladoc

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

1

SET UP YOUR ACCOUNT

Set up your account by phone (toll-free) web, mobile app or by texting "Get Started" to 469-844-5637.

Online:
Go to Teladoc.com and click **"set up account"**.

Mobile app:
Download the app and click **"Activate account"**. Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.

2

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3

REQUEST A CONSULT

Once your account is setup, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Talk to a doctor anytime for **free!**

Teladoc.com
1-800-Teladoc (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

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Teladoc® Member Frequently Asked Questions

What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality medical care through phone and video consults.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Does Teladoc replace my doctor?

No. Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

What kind of medical care does Teladoc provide?

When requesting a consult, you can choose between general medical, behavioral health or dermatology.

What consult methods are available?

You can talk with a Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app.

How do I set up my Teladoc account?

Setting up your account is a quick and easy process online. Visit the Teladoc website and click "Set Up Account". Follow the online instructions.

How do I request a consult to talk to a doctor?

Visit the Teladoc website, log into your account and click "Request a Consult". You can also call Teladoc to request a consult by phone.

How quickly can I talk to the doctor?

A doctor will call you back in 16 min, on average. If you miss the doctor's call, whether you are away from the phone or you have anonymous call blocker on, you will be returned to the bottom of the waiting list. The consult request is cancelled if you miss three calls.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

Yes, Teladoc doctors can prescribe short-term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, non-therapeutic and/or certain other drugs which may be harmful because of their potential abuse.

How do I pay for a prescription called in by Teladoc?

When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.

Can I provide consult information to my doctor?

Yes. You have access to your electronic medical record at anytime. Download a copy online from your account or call Teladoc and ask to have your medical record mailed or faxed to you.

Talk to a doctor anytime for Free

Teladoc.com

1-800-Teladoc

Facebook.com/Teladoc

Teladoc.com/mobile

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Employee Assistance Program
School City of Mishawaka-EAP Services

New Avenues
Midwest Behavioral Health Network

School City of Mishawaka offers eligible employees and the family members living in their households an Employee Assistance Program with New Avenues, Inc. New Avenues offers confidential counseling through a network of licensed clinicians located close to your home or workplace. These trained professionals are ready to help you deal with family or work/life issues that may be causing your life to feel out of balance.

*All services are strictly confidential and at **no cost** to the employee or family members.*

Common Questions…

WHO IS ELIGIBLE?

- All active full & part-time employees and the eligible family members living in their households.
- Dependents up to age 26, not living in the home of the employee, are eligible if on the employee's health insurance.
- Per Diem, temporary employees, volunteers, and student/interns are excluded.
- Starts first date of active employment.
- Eligibility runs through the last day of employment.

WITH WHAT TYPES OF PROBLEMS CAN NEW AVENUES COUNSELORS HELP?

- Stress
- Anxiety
- Workplace Issues
- Personal Concerns
- Substance Abuse
- Grief
- Marriage/Family/Relationship problems

HOW MANY COUNSELING SESSIONS DO I HAVE?

- There are **5** Face-to-Face EAP sessions per employee family per contract year.
- The contract year runs from **November 1st through October 31st.**

WHAT IF I NEED MORE THAN 5 SESSIONS?

Once you have used your EAP sessions, you are responsible for fees incurred for additional sessions. You may choose to continue services under the terms of your health plan benefit. (See your health plan SPD for a description of covered services). New Avenues makes every attempt to arrange your EAP sessions with a counselor who is in your health plan network so you may continue with the same person.

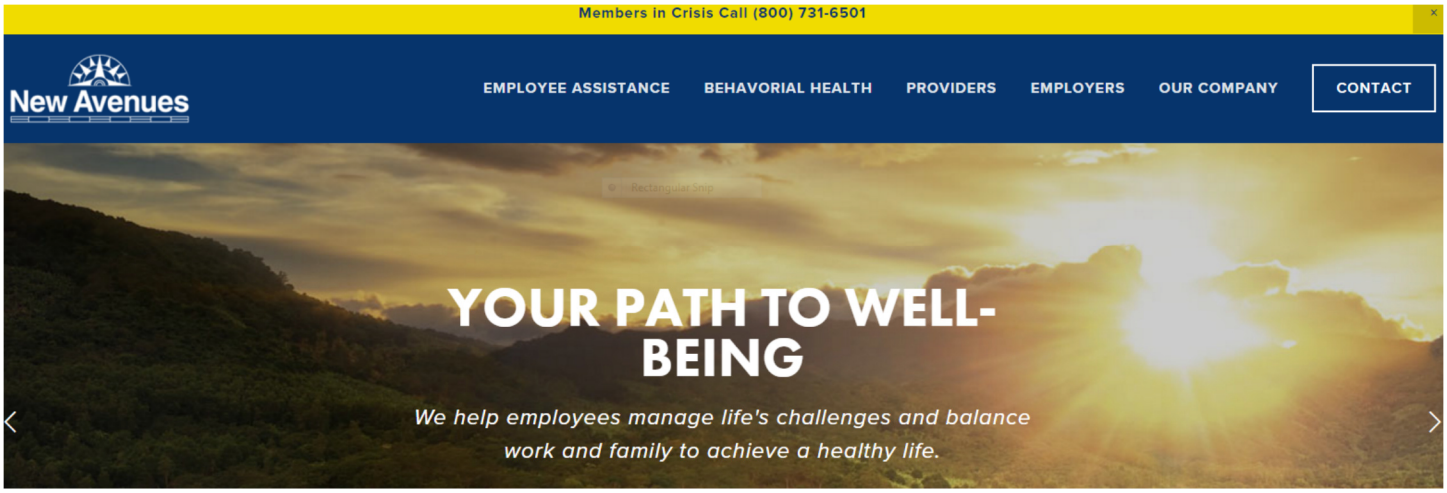
HOW DO I ACCESS MY FACE-TO-FACE EAP SESSIONS?

Just call New Avenues at: **800-731-6501 or 574-232-2131**. Select option **#2.** Services are strictly **confidential** and there is **no out-of-pocket cost** to you or to your family members.

Structured Telephonic Counseling

In addition to face-to-face counseling, New Avenues offers telephonic counseling (855-492-3625) as well as an array of online support services available 24/7. Log-on to the New Avenues website at **http://www.NewAvenuesOnline.com**

New Avenues Toll Free # 800-731-6501



RESOURCES AVAILABLE at NewAvenuesOnLine.com ARE:

WORK-LIFE RESOURCE CENTER: Your **Password** is: **EAP.**

A web-based information center containing a wealth of articles, useful tips, interactive tools and links as well as access to Structured Telephonic Counseling (855-492-3625) offering live counselors that can be accessed 24/7 from the comfort of your home. Don't forget to sign up for the Savings Center, a free program where you will have access to savings of up to 25% on name-brand, everyday, and luxury items. Access the Work-Life Resource Center under the Employee Assistance tab on our home-page.

NEW AVENUES PROVIDER DIRECTORY:

A listing of licensed and credentialed counselors and therapists in the New Avenues EAP Network.

NEWS:

Articles on a variety of topics, such as Parenting, Child Care, Responsibility, Financial Assistance, that provide tips for improving the well-being of your professional and personal life. Don't miss the monthly featured articles on topics such as: Home Buying, Connecting with your loved ones, Importance of sleep, and Stress relief techniques.

ADDITIONAL RESOURCES AVAILABLE ARE:

MEDLINEplus Drug Information

A comprehensive guide to more than 9,000 prescription and over the counter medications.

PubMed

Click onto Health Information and then Medline/PubMed. PubMed is a service of the National Library of Medicine and provides access to over 11 million citations from MEDLINE and additional life science journals.

Facts for Families from the American Academy of Child & Adolescent Psychiatry

Specific to children and adolescents. This site offers information on a number of issues and diagnoses for this age group.

Surgeon General Reports

The U.S. Surgeon General's office has produced three landmark reports covering mental health topics. Reports on Mental Health, Suicide Prevention, Children's Mental Health, and Youth Violence can be accessed through this site.

National Council for Alcohol and Drug Abuse

Provides education, information, health and hope to the public.

To access these and other helpful links follow the *Resource* link under *Our Company*

New Avenues
Midwest Behavioral Health Network

Confidentiality Notice:

"New Avenues and the clinical providers in it's network are required by law to report any cases of suspected child abuse, elder abuse, or threats of physical harm to one's person or other individuals."

Toll Free: 800-731-6501

Your Cost in 2021

EMPLOYEE PAYCHECK DEDUCTIONS				
	Employee 26 Pays	Employee & Family 26 Pays	Employee 19 Pays	Employee & Family 19 Pays
Medical	$20.13	$131.16	$27.54	$179.48
Dental	$3.48	$16.29	$4.76	$22.29
Vision	$1.28	$3.31	$1.75	$4.53

DISABILITY INCOME BENEFITS

School City of Mishawaka, provides full-time employees with short- and long-term disability income benefits at minimal cost. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

We want to do everything we can to protect you and your family. If you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, you are not eligible to receive disability benefits if you are receiving workers' compensation benefits.

	Class 1	Class 2	Class 3
Monthly Benefits	66 2/3%	66 2/3%	66 2/3%
Maximum Monthly Benefits	$5,000	$3,700	$2,000
Minimum Monthly Benefit	$100	$100	$100
Definition of Earnings	Base Salary	Base Salary	Base Salary
Elimination Period	90 Days	90 Days	90 Days
Accumulation of EP	2xEP	2xEP	2xEP
Maximum of Duration	SSNRA	SSNRA	SSNRA
Definition of Disability	2 years own occupation, with Residual	2 years own occupation, with Residual	2 years own occupation, with Residual
Return to Work	12 Months	12 Months	12 Months

BASIC LIFE INSURANCE

School City of Mishawaka, Life insurance can help provide for your loved ones if something where to happen to you. provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance. Please contact Human Resources to update any beneficiary information.

Benefit	Basic Life
All Active Certified & Non-Certified Employees	$50,000
All Active School Board Members, Superintendents and Administrators	$200,000
All Eligible Retirees	$3,000
	AD&D
All Active Certified & Non-Certified Employees	$50,000
All Active School Board Members, Superintendents and Administrators	$200,000
Benefit Reduction	• To 65% at the age of 70 • To 45% of the original amount at age 75 • To 30% of the original amount at age 80
	Life
Spouse Amount	$10,000
Child(ren) Amounts	• $500 Child(ren): birth to 6 months • $5,000 Child(ren): 6 months to 26 years

PARAMOUNT DENTAL
Affiliate of ProMedica

Product Summary Guide for School City of Mishawaka

DHO 9 (November - December)

Plan Annual Maximum Benefit:	$1,500	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Core build ups	Covered at 80%	Covered at 80%
Crowns – porcelain, ceramic, stainless steel	Covered at 80%	Covered at 80%
Fillings - silver or white (anterior and posterior teeth)	Covered at 80%	Covered at 80%
Protective restorations	Covered at 80%	Covered at 80%
Removable dentures	Covered at 80%	Covered at 80%
Endodontics & Periodontics		
Root canal therapy – anterior, posterior	Covered at 80%	Covered at 80%
Scaling and root planing	Covered at 80%	Covered at 80%
Full mouth debridement	Covered at 80%	Covered at 80%
Periodontal maintenance	Covered at 80%	Covered at 80%
Oral Surgery		
Frenectomy	Covered at 80%	Covered at 80%
Simple extractions	Covered at 80%	Covered at 80%
Impactions	Covered at 80%	Covered at 80%
Surgical extractions	Covered at 80%	Covered at 80%
Miscellaneous		
Implants	Covered at 50%	Covered at 50%
Emergency palliative treatment	Covered at 100%	Covered at 100%
Anesthesia – general and IV sedation	Covered at 80%	Covered at 80%
Deductible (Not applicable on Diagnostic & Preventive):	**$25 / $50**	**$25 / $50**
Lifetime Orthodontic Benefit (Dep. Child):	**$1,500**	
Out of Network Reimbursement	**90th Percentile**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment

Interceptive Orthodontic Treatment

Comprehensive Orthodontic Treatment

Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terms of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling HRI at 800-727-1444.

To find a dentist visit: InsuringSmiles.com/FindADentist

Your Vision Benefits Summary

Get access to the best in eye care and eyewear with SCHOOL CITY OF MISHAWAKA and VSP® Vision Care.

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.** The decision is yours to make—with the largest national network of private-practice doctors, it's easy to find the in-network 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.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

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.

Plan Information

VSP Coverage Effective Date: 11/01/2018
VSP Provider Network: VSP Choice

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$20
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every 12 months	$0 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Primary Eyecare	• Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, 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	
Your Coverage with Out-of-Network Providers		
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.		

VSP guarantees coverage from VSP network providers only. 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.

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.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT

Under the Newborn's & Mothers' Health Protection Act, the Plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean delivery.

Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the plan's utilization reviewer does not think such a stay is medically necessary.

The plan must eliminate this preauthorization requirement with respect to hospital stays following vaginal delivery for the first 48 hours (or 96 hours in the case of a cesarean section).

The plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this plan (within the 48/96 hour period and based on medical necessity) must be eliminated. For more information see www.dol.gov

WOMEN'S HEALTH & CANCER RIGHTS ACT

In accordance with the Women's Health and Cancer Rights Act of 1998, SIHO Insurance Services' covered members who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetric appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

For more information call Auxiant Health at (800) 475-2232.

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2023)

We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family. After reviewing this benefit guide, please feel free to contact Auxiant Health at **800-475-2232** with any questions.

This brochure is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. The entire provisions of benefits and exclusions are contained in the Summary Plan Document (SPD). In the event of a conflict between the SPD and this Guide, the terms of the SPD will prevail.

SAINT JOSEPH HEALTH SYSTEM
ACCOUNTABLE CARE ORGANIZATION

Administered by:
Auxiant
Independent Solutions › Real Results