



HSS

2021 Health Benefits Guide

■ Welcome To Health Choice

What's New for 2021

Enrolling for 2021

Your Health Choice Options

How Health Choice Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending
Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Welcome to Health Choice

Different people have different benefit needs. Some prefer a particular type of medical plan. Some need more life and accident insurance. Some are looking for ways to save on taxes. You're the only person who knows which of these features are most important to you. With *Health Choice*, you can choose among a number of benefit options, so your overall benefits program better reflects your personal situation.

What's New for 2021

Dental Insurance Changes

For 2021, we have a new dental carrier-Met Life. This change in dental carrier ensures we meet the diverse needs of our employees.

Enhancements:

The calendar year maximum is increasing by \$250. The new calendar maximum for the Voluntary plan is \$3,250 and for the Traditional \$1,850. The out-of-network reimbursement is increased to 99th percentile of R&C.

The in-network providers is increasing by 10%. This translate to more savings as your cost is less when utilizing your in-network benefits. Your current plan will be defaulted to 2021 but the carrier will not be Guardian but MetLife.

Prescription Drug Coverage Changes

Prescription drugs are vital to good health care, but are increasingly complex and expensive, requiring careful management to protect your health.

Beginning January 1, 2021, we are offering these additional prescription program at no cost to you:

■ **Pulmonary Care Value Program:** Remote monitoring system to track adherence to pulmonary medications and live member outreach for additional education.

■ **Diabetes Care Value Program:** Free connected glucose monitor & scale Helps eligible members monitor blood sugar & shares values with providers to provide better clinical care; scale provided to at risk pre-diabetics along with lifestyle coaching.

This guide summarizes Hospital for Special Surgery's benefit plans. The actual plan provisions are contained in legal documents and contracts. If there is a discrepancy between the information in this guide and the provisions of the documents and contracts, the terms of the documents and contracts will prevail. Hospital for Special Surgery reserves the right to amend or terminate these benefits at any time. Any such amendments to the plan will be made in writing and adopted by the Board of Trustees. The information in this booklet does not constitute a contract of employment.

Voluntary Life and AD&D Insurance Changes

For 2021, we are updating the structure of the voluntary life plan-your basic life is not changing.

Your voluntary life insurance coverage will change

* Currently, this coverage is offered in increments of \$20,000. Effective 1/1/2021, this coverage will only be offered as a multiple of your salary and for currently enrolled employees half increment (0.5, 1, 1.5, etc up to 5x) will be available.

* All currently **enrolled** employees will be **defaulted** to the next higher half salary increment. Any default amount over the guarantee issue amount would require evidence of insurability.

Special opportunity

During our 2021 Open Enrollment period, you may also increase your coverage up to the plan maximum of \$1,500,000 or up to 5xs your salary (whichever is lesser) Any amount exceeding the Guaranteed Issue Amount of \$1,000,000, will require Evidence of Insurability and need to be approved before the coverage goes into effect. Both the plan maximum and Guaranteed Issue Amount include your company paid and voluntary coverage. This and any other changes to your coverage can be done in the bswift open enrollment portal. See page 38 for more details.

■ **No change** to current plan maximum of a combined \$1.5M Basic and Supplemental Life

■ **No change** to current plan guarantee issue of a combined \$1M Basic and Supplemental Life

■ **No change** to the Basic Life

■ Welcome To Health Choice

What's New for 2021

Enrolling for 2021

Your Health Choice Options

How Health Choice Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending
Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Enrolling for 2021

If you wish to participate, or continue participation, in the Flexible Spending Accounts, IRS rules require you to make an election each year. You must make this election through the Benefits Administration website — www.hss.bswift.com.

If you elect to participate in the HSA **you are not eligible to participate in the Health Care Spending Account.**

Become Tobacco-free through Quit For Life®

The Quit For Life Program is sponsored by the American Cancer Society® and Alere Wellbeing. These two organizations have 35 years of combined experience in tobacco cessation coaching and have helped more than 1 million tobacco users. The program integrates free medication, web-based learning and confidential phone-based support from expert Quit Coaches®.

The program includes, at no cost to you:

- Up to five outbound coaching calls with a Quit Coach.
- Nicotine replacement therapy (8 weeks of patch/gum) mailed directly to your home if appropriate.
- Access to Web Coach®, a private, online community where you can complete activities, watch videos, track your progress and join in discussions with others in the program.
- An easy-to-use printed workbook that you can reference in any situation to help you stick with your quitting plan.
- Recommendations on type, dose and duration of nicotine replacement or medication if appropriate (including patch, gum, bupropion or Chantix™).
- Text messaging support.
- Unlimited toll-free access to Quit Coaches, who offer as much or as little support as you need.

To enroll or learn more, call **1-866-QUIT-4-LIFE (1-866-784-8454)** or visit www.quitnow.net.



Important Reminders

- **Low Plan closed to new enrollees.** If you are currently enrolled in the Low Plan for 2020, you may continue that coverage for 2021. Keep in mind that once you leave this plan, you will no longer be able to re-enter into the Low Plan.
- **Tobacco annual premium surcharge.** If you certified your tobacco status during open enrollment for 2020, you are not obligated to re-certify for 2021 unless your status has changed. **If you certified as a tobacco user, you will continue to be assessed the \$250 annual premium surcharge.**

■ Welcome To Health Choice

What's New for 2021

Enrolling for 2021

Your Health Choice Options

How Health Choice Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending
Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Your Health Choice Options

The following is a brief summary of your *Health Choice* options. Each plan is described in more detail later in this booklet:

- **Medical (United Healthcare)** — With *Health Choice*, you can choose from four different medical options. The EPO is the only option that does not offer out-of-network benefits. None of the four options require you to choose a primary care physician. **Note:** The Low Plan is closed to new enrollees, but available in 2021 for those currently enrolled.
- **Dental (MetLife)** — The Health Choice Dental Plan offers three options: the MetLife DMO, the MetLife Traditional and the MetLife Optional Voluntary. The MetLife DMO requires that you see an in-network dentist.
- **Vision (Guardian)** — The Health Choice Vision Plan offers eye care such as exams, frames/lenses, and contact lenses.
- **Long Term Disability (LTD) Insurance (Hartford)*** — You will receive basic coverage of 60% of your annual salary, with a maximum benefit of \$1,200 per month. Plus, you may purchase voluntary coverage if you want additional financial protection.
- **Life Insurance (Hartford)*** — You will receive basic coverage of one times your salary. You can also elect additional voluntary coverage as a multiple of your salary, not to exceed 5 times your salary. The combined basic and voluntary coverage has a maximum benefit of \$1.5 million.
- **Accidental Death & Dismemberment Insurance (Hartford)** — You will receive basic coverage of \$50,000. You can also elect additional voluntary coverage a multiple of your salary, not to exceed 5 times your salary. The combined basic and voluntary coverage has a maximum benefit of \$1.5 million.

** Electing voluntary Long-Term Disability or Life Insurance coverage outside of your initial enrollment period and during open enrollment will require you to complete the Personal Health Application and submit to Hartford for approval. Coverage will not be effective until the date Hartford approves the application.*

- **Health Savings Account (HSA) with the Consumer Directed Health Plan (CDHP)** — If you enroll in the Consumer Directed Health Plan, you have access to a Health Savings Account (HSA) to help pay for eligible medical expenses with pre-tax dollars. This account is similar to a Flexible Spending Account (FSA), but with some important differences — such as employer-made contributions to your account from HSS in 2021 and the ability to roll over an HSA balance from year to year. Unlike the FSA there is no “use it or lose it” rule for the HSA. See the **“Health Savings Account”** section in this guide for more details.
- **Flexible Spending Accounts (Ultra Benefits)** — You can save on taxes with the Health Care and Dependent Care Spending Accounts. Each account lowers your taxable income by letting you pay for certain expenses with pre-tax dollars. The maximum annual contribution for the Health Care Spending Account is \$2,750 and \$5,000 for the Dependent Care Spending Account (for eligible child care expenses). If you elect to participate in the HSA, you are not eligible to participate in the Health Care Spending Account.



■ **How Health Choice Works**

The Pre-Tax Advantage

Eligible Employees

When Coverage Begins

Changing Your Coverage

Coverage Levels

What Happens If You Don't Enroll?

Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

How Health Choice Works

With *Health Choice*, you decide which benefits are right for you and your family. Each option has an employee contribution, which is the amount you contribute toward the cost of your coverage. The employee contributions are listed on the Benefits Administration website at www.hss.bswift.com.

The Pre-Tax Advantage

Remember, with *Health Choice*, many of your benefit contributions are made on a pre-tax basis. How much can you save by paying for your medical and dental coverage on a pre-tax basis? That depends on a number of factors, including your marital status, number of dependents and annual salary.

Tax Savings Example

Here's an example. Let's assume that you're married with one child and earn \$50,000 per year. Let's also assume that your contributions toward the cost of medical and dental coverage are \$4,322 per year.

	Pre-Tax Deductions	After-Tax Deductions
Pre-tax Payroll Deductions for Benefits	\$4,322	\$0
Estimated Federal Income and FICA Taxes	\$7,534	\$8,512
After-tax Payroll Deductions for Benefits	\$0	\$4,322
Take-home Pay	\$38,114	\$37,166

In this example, you will add approximately \$950 to your annual take-home pay simply by having your medical and dental payroll deductions made on a before-tax basis. As you consider your options, you should note that you won't pay Social Security taxes on those pre-tax deductions. As a result, your wages reported for Social Security purposes will be marginally reduced, which could slightly lower your Social Security benefits at when you retire. In general, however, the immediate tax savings will usually outweigh any reduction in your eventual Social Security retirement benefits.

Eligible Employees

If you are a regular full-time employee or a part-time employee working at least 20 hours a week, you are eligible for *Health Choice* benefits after you satisfy the applicable waiting period. If you are eligible, you can also elect medical, dental and vision coverage for certain dependents. Your eligible dependents include you:

- Spouse
- Domestic partner (contact Human Resources for eligibility requirements)
- Your children, up to age 26 for medical, prescription, dental and vision coverage (coverage ends at end of calendar year the dependent turns 26)
- Physically or mentally disabled children of any age who are totally dependent on you for support

You will be required to provide proof of status for any new dependents you are enrolling during your new hire or newly eligible initial enrollment and open enrollment. Enrollment for these dependents will be classified in pending status until this documentation is received. Proof of status documentation includes:

- Spouse: Copy of marriage certificate or license issued by state or local government
- Child: Copy of birth certificate
- Domestic Partner: Domestic partner affidavit (contact HR for affidavit)

Note: The amount that HSS contributes to the coverage of a domestic partner and, if applicable, the domestic partner's child(ren), will be reported as imputed income

Part-Time Employees

HSS allows part-time employees to participate in the *Health Choice* benefits program. Please be advised that there may be a significant difference in the cost of benefits for part-time employees. See [page 8](#) for more information.

Welcome To *Health Choice*

■ How *Health Choice* Works

The Pre-Tax Advantage

Eligible Employees

When Coverage Begins

Changing Your Coverage

Coverage Levels

What Happens If You Don't Enroll?

Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending
Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

When Coverage Begins

If you enroll during the open enrollment period, most *Health Choice* coverage begins on the following January 1.

If you enroll as a new hire:

- **Benefits are effective as of your date of hire. You have 30 days following your date of hire to enroll.**

Voluntary Long-Term Disability coverage and Voluntary Life Insurance coverage elected during open enrollment require completion and submission of a Personal Health Application. You will be sent to the Hartford website to complete the Personal Health Application, following completion of your enrollment. Should Hartford approve your application, you will receive notification of the coverage effective date.



Changing Your Coverage

The choices you make during enrollment remain in place through December 31, 2021.

If you enroll in the CDHP, you can change your HSA contribution during the year through the Benefits Administration website at, www.hss.bswift.com. You do not have to experience one of the following changes in life status to change your HSA election.

For all other medical, dental and vision coverage, and flexible spending accounts, the following changes in life status allow you to change your benefits:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or child
- A change in your spouse's employment that results in loss or gain of coverage
- Loss of other coverage

■ **How Health Choice Works**

- The Pre-Tax Advantage
- Eligible Employees
- When Coverage Begins
- Changing Your Coverage**
- Coverage Levels
- What Happens If You Don't Enroll?
- Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Changing Your Coverage

Any benefit change that you make must be a direct result of your change in life status. For example, if you get married, you can change your coverage level from individual to family. **Please note that you have 30 days from the date of the event to make your change. The rules of our plan do not allow us to accept changes if you miss the 30-day deadline, and you will have to wait until the next Open Enrollment period. DO NOT wait** until you have received your documents, such as marriage certificate, birth certificate, social security card, etc., to make your changes through the Benefits Administration Website See the chart below for more information or contact Human Resources.

Qualifying Event	Medical/Dental/Vision	Spending Accounts		Coverage Will Begin or End
		Health Care	Dependent Care	
Marriage	Elect/decline coverage Increase/decrease coverage level	Elect coverage Increase contribution	Elect/decline coverage Increase/decrease contribution	First of the month following completion of a life event enrollment
Birth or Adoption of a Child	Elect/decline coverage Increase/decrease coverage level	Elect coverage Increase contribution	Elect/decline coverage Increase/decrease contribution	Day of the event
Legal Separation or Divorce	Elect/decline coverage Increase/decrease coverage level	Elect coverage Increase contribution	Elect/decline coverage Increase/decrease contribution	First of the month following completion of a life event enrollment
Change in Spouse's Employment or Loss of Spouse's Employment	Elect/decline coverage Increase/decrease coverage level	Elect coverage Increase contribution	Elect/decline coverage Increase/decrease contribution	First of the month following completion of a life event enrollment
Loss of other coverage	Elect/decline coverage Increase/decrease coverage level	Elect coverage Increase contribution	Elect/decline coverage Increase/decrease contribution	First of the month following completion of a life event enrollment
Death of a Spouse or Qualified Dependent*	Increase/decrease coverage level	Elect coverage	Elect/decline coverage Increase/decrease contribution	Day of the event
Cease to Qualify as a Dependent*	Increase/decrease coverage level	N/A	Elect/decline coverage Increase/decrease contribution	First of the month following completion of a life event enrollment
Gain/Loss of Domestic Partner's Employment or Benefits*	Elect/decline coverage Increase/decrease coverage level	N/A	N/A	First of the month following completion of a life event enrollment
Change of Address (resulting in a change in medical provider's service area, which affects your choice of plans)	Elect/decline coverage Proof of address change required; must satisfy hospital requirements (driver's license not acceptable)	N/A	N/A	First of the month following completion of a life event enrollment

*See the definition of an eligible dependent on [page 5](#).

Note: Once you enroll in the Health Care Spending Account, you cannot cancel this benefit for the remainder of the plan year.

If you acquire a new dependent because of a marriage, birth or adoption, you can enroll yourself and any eligible dependents for medical coverage, even if you have previously waived coverage. In this situation, you must complete a Life Event enrollment through the Benefits Administration website at www.hss.bswift.com within 30 days of the marriage, birth or adoption. You will be eligible to enroll under any medical option or coverage level normally available to you. (Please see chart above.)

If adding a child under the age of 1 year old to your coverage, the social security number is **not required** to complete the online Life Event enrollment. Once you enter your child's date of birth the system will change the social security field from a required field to **not required**. As soon as you receive your child's social security number, please update it on the Benefits Administration Website.

■ **How Health Choice Works**

- The Pre-Tax Advantage
- Eligible Employees
- When Coverage Begins
- Changing Your Coverage
- Coverage Levels**
- What Happens If You Don't Enroll?
- Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Coverage Levels

Coverage levels available for Medical, Dental, Vision include:

- Employee Only
- Employee + Family

Employee Benefit Costs

(Assumes non-smoker)

	Tier	FULL-TIME (Per-Paycheck)	PART-TIME (Per-Paycheck)
Medical			
UHC High Plan	Single	\$95.62	\$95.62
	Family	\$231.97	\$463.94
UHC Low Plan	Single	\$68.87	\$68.87
	Family	\$168.41	\$336.81
UHC EPO Plan	Single	\$49.75	\$49.75
	Family	\$105.42	\$210.83
UHC Premium Plan	Single	\$353.54	\$353.54
	Family	\$844.51	\$1,634.54
UHC CDHP	Single	\$25.30	\$25.30
	Family	\$54.68	\$109.36
Dental			
MetLife Optional Voluntary	Single	\$14.75	\$14.75
	Family	\$41.55	\$74.20
MetLife Traditional	Single	\$2.73	\$2.73
	Family	\$7.67	\$15.34
MetLife DMO	Single	\$0.89	\$0.89
	Family	\$2.29	\$4.57
Vision			
Guardian Vision	Single	\$2.95	\$2.95
	Family	\$7.75	\$7.75

■ **How Health Choice Works**

- The Pre-Tax Advantage
- Eligible Employees
- When Coverage Begins
- Changing Your Coverage
- Coverage Levels

What Happens If You Don't Enroll?

- Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

What Happens If You Don't Enroll?

If you are currently enrolled, you will continue to receive the benefits you had in effect during 2020, with the exception of the Flexible Spending Accounts, which require an annual election.

For new employees with an eligibility date of January 1 or later:

If you are a new employee with a benefits eligibility date of January 1, 2021, or later, you must enroll through the Benefits Administration Enrollment site during your new hire enrollment period. If you don't complete your enrollment, you will be assigned the following elections by default:

Coverage	Default Election
Medical	EPO, single coverage level, tobacco use surcharge
Dental	MetLife DMO, single coverage level
Life Insurance	Basic coverage of 1x salary
Accidental Death & Dismemberment (AD&D)	Basic coverage of \$50,000
Long-Term Disability (LTD)	Basic coverage of 60% of monthly salary, to a maximum benefit of \$1,200 per month

If you receive default coverage, the necessary contributions will automatically be deducted from your pay **plus \$250** (annual amount) for the tobacco use surcharge.

Receiving default coverage is not the same as waiving coverage

If you are covered under another health insurance plan in 2020 and elect not to be covered under *Health Choice* in 2021, you must elect the "Waive" option on the Benefits Administration website. Failure to complete your enrollment will result in you being enrolled in the default coverage listed in the chart. You will not have the opportunity to waive this coverage until the next open enrollment period.



■ **How Health Choice Works**

- The Pre-Tax Advantage
- Eligible Employees
- When Coverage Begins
- Changing Your Coverage
- Coverage Levels
- What Happens If You Don't Enroll?

Terms to Know

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending
Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Terms to Know

The remainder of this booklet describes your various *Health Choice* options in more detail. To help you understand how each option works, here are some important terms you should know:

Coinsurance

The percentage of costs you and the plan each pay, after you meet the deductible. This applies to the MetLife Traditional Dental Plan and to your medical plans after you satisfy the deductible either in or out of network. If your medical plan covers both in- and out-of-network services, your in-network coinsurance will be lower (you'll pay less) than your out-of-network coinsurance.

Copayment

This is a flat fee (copay) you pay to your health care provider and prescription provider.

You pay a copayment for office visits, emergency room visits and prescription drugs on medical plans except the CDHP, all when you go to a provider in-network.

Deductible

This is the amount you must pay toward your covered expenses each year before the plan begins to pay benefits. Your deductible depends on the coverage level you select — individual or family — and the plan you choose. Depending on your plan, some expenses do require you to first meet the deductible. If your plan covers both in- and out-of-network services, your in-network deductible will be lower than your out-of-network deductible.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you can be required to pay toward your covered expenses each year. In most cases, once this limit is reached, the plan pays 100% of your covered expenses for the rest of that year. (However, you may be responsible for expenses for services not covered by the plan, or amounts in excess of the reasonable and customary limits.)

Preventive Care Services

Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, checkups and patient counseling to prevent illness, disease or other health problems.

Reasonable and Customary Expense Limits

Reasonable and customary (R&C) limits are the prevailing rates charged for a surgical procedure, medical service or supply, taking into account the geographic area in which the services are provided. When R&C limits apply, reimbursements will not exceed these amounts. You will be responsible for paying the difference between the R&C limit and the rate charged. This does not apply to in-network providers. Only when you utilize an out-of-network provider does the possibility of you being responsible for paying the amount in excess of the R&C limit apply.

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review
- Comparing Your Medical Options
- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Medical Plan

The *Health Choice* Medical Plan protects you and your covered dependents against the high cost of medical care. Under the program, you can choose from four medical options:

- [High Plan](#)
- [Exclusive Provider Organization \(EPO\) Plan](#)
- [Consumer Directed Health Plan with HSA \(CDHP\)](#)
- [The Premium Plan](#)

The [UnitedHealthcare Low Plan](#) option is closed to new enrollees, but remains open in 2021 for those currently enrolled.

You can also waive coverage entirely if you have coverage from another source.

You can choose coverage for:

- Yourself only (Single Coverage), or
- Yourself and your family (Family Coverage)

To search for an in-network provider, hospital or lab, please visit www.myuhc.com.

The network name for the EPO Plan is Choice. The Choice Plus Network includes the High, Low, CDHP and Premium Plans.

Each *Health Choice* medical option is described in more detail on the pages that follow. Please review this information carefully, so you can choose the medical plan that is right for you and your family.

The SPDs are available on the Benefits Administration website — www.hss.bswift.com — in the Library section.

Health Choice Employee Discount

HSS provides a discount when you utilize HSS facilities who participate in your health plan. United Healthcare automatically applies the 50 percent discount at the time the claim is processed.

Let's take a look at how this works, assuming you are enrolled in the EPO Plan, have not incurred any expenses yet and need to have a surgery that costs \$10,000 before insurance.

Non-HSS Facility		HSS Facility	
Plan Benefit	Out-of-Pocket Cost	Plan Benefit	Out-of-Pocket Cost
Meet Your In- Network Deductible	\$350	Meet Your In- Network Deductible	\$175
Pay 8% of the remaining amount	\$772	Pay 4% of the remaining amount	\$393
Total Member Cost	\$1,122	Total Member Cost	\$568

Provisions

HSS employees, their spouses, domestic partners, and children up to the age of 26, who are covered under Health Choice plans that provide hospital benefits in the United States, are eligible for this discount. Claims for covered hospital services will be submitted to your insurance carrier and processed for payment in accordance with your benefit plan. Claims will be automatically processed with a 50 percent discount. Due to IRS regulations, the discount cannot be applied to the deductibles of the CDHP. CDHP participants will benefit from this discount once the annual deductibles are met and claims are processed with a coinsurance.

Welcome To *Health Choice*

How *Health Choice* Works

■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

The UnitedHealthcare High Plan

The High Plan option is similar to a Point of Service plan (POS). If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network. To remain in network, you must receive care from a provider within the Choice Plus network.

- **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment. Non-preventive services are covered as follows:
 - Physician services: The plan pays 100% after a \$30 copayment for Primary Care Physicians (PCPs) or a \$50 copayment for specialists.
 - Emergency Room visit: The plan pays 100% after a \$150 copayment.
 - For inpatient hospital admission and most other services: The plan pays 95% after you pay an annual deductible of \$350 for individual coverage, or \$875 for family coverage
 - Once you reach the out-of-pocket maximum (\$2,000 per individual, or \$4,000 for a family), the plan pays 100% of any remaining costs (medical copayments) for the year.

- **Out-Of-Network** — If you choose an out-of-network provider, for most services, the plan pays 70% after you satisfy an annual deductible (\$1,100 per individual, or \$2,750 per family). You are responsible for filing claim forms no later than 180 days from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Once you reach the out-of-pocket maximum (\$4,000 per individual, or \$10,000 for a family), the plan pays 100% of any remaining costs for the year (coinsurance). However, you are still responsible for paying 100% of any amounts above the R&C limit an out-of-network provider may charge.



■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Special Circumstances

The following special circumstances can affect the benefits under the High Plan for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call UnitedHealthcare within 48 hours at **1-888-761-0337**. If you comply with these procedures, your copayment will be waived, and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefits you receive.
- **You Must Pre-certify All Surgical or Major Diagnostic Procedures** — An exception is made when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call UnitedHealthcare at **1-888-761-0337** at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements.
- **If Your Dependent is a Student Away at School** — Under this plan, dependents may see in- or out-of-network providers throughout the country. If you prefer to stay in-network, simply call the number on the back of your card (**1-888-761-0337**), and a service representative will direct you to a Choice Plus network provider in the area. You can also search for an in-network provider by visiting www.myuhc.com.

Prescription Drug Benefits Provided by Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs counts toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay \$10 for generic, \$30 for brand name and \$50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.
- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.
- **Mail-Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail-order program, you can receive up to a 90-day supply of medication. All you have to pay is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs.
- **Brand-Name Drugs** — If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand-name copay plus the difference in cost between the generic and brand name.
- **Out-Of-Pocket Maximum** — Once you reach the prescription drug out-of-pocket maximum (\$2,000 per individual, or \$4,000 for a family), the plan pays 100% of any remaining prescription drug costs for the year.



■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

The UnitedHealthcare Low Plan

The Low Plan is only an option for 2021 enrollment for those enrolled in the plan in 2020.

This plan offers the same selection of health care providers and in-network benefits as the High plan. However, the plan has a higher deductible and out-of-pocket expense limit when using out-of-network providers.

If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network. To remain in network, you must receive care from a provider within the Choice Plus network.

■ **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment.

Non-preventive eligible services will be covered as follows:

- Physician services: The plan pays 100% after a \$30 copayment for Primary Care Physicians (PCPs) or a \$50 copayment for specialists.
- Emergency Room visit: The plan pays 100% after a \$150 copayment.
- Inpatient hospital admission and most other services: The plan pays 95% after you pay an annual deductible of \$350 for individual coverage, or \$875 for family coverage
- Once you reach the out-of-pocket maximum (\$2,000 per individual, or \$4,000 for a family), the plan pays 100% of any remaining costs (medical copays) for the year.

In addition, your physician will submit your claims for reimbursement.

■ **Out-Of-Network** — If you choose an out-of-network provider, most services will be covered at 70% after you satisfy an annual deductible (\$2,100 per individual, or \$5,250 per family). You are responsible for filing claim forms no later than 180 days from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the fee limits established by the plan.

Once you reach the out-of-pocket maximum (\$5,000 per individual, or \$12,500 for a family), the plan pays 100% of any remaining costs for the year (coinsurance). However, you are still responsible for paying 100% of any amounts above the fee limits established by the plan.

■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Special Circumstances

The following special circumstances can affect the benefits under the Low Plan for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call UnitedHealthcare within 48 hours at **1-888-761-0337**. If you comply with these procedures, your copayment will be waived, and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.
- **You Must Pre-certify All Surgical or Major Diagnostic Procedures** — An exception is made when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call UnitedHealthcare at **1-888-761-0337** at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements for you.
- **If Your Dependent is a Student Away at School** — Under this plan, dependents may see in- or out-of-network providers throughout the country. If you prefer to stay in-network, simply call the number on the back of your card (**1-888-761-0337**), and a service representative will direct you to a Choice Plus network provider in the area. You can also search for an in-network provider by visiting www.myuhc.com.

Prescription Drug Benefits Provided by Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs counts toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay \$10 for generic, \$30 for brand name and \$50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.
- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.
- **Mail-Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail-order program, you can receive up to a 90-day supply of medication. All you have to pay is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs.
- **Brand-Name Drugs** — If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand-name copay plus the difference in cost between the generic and brand-name
- **Out-Of-Pocket Maximum** — Once you reach the prescription drug out-of-pocket maximum (\$2,000 per individual, or \$4,000 for a family), the plan pays 100% of any remaining prescription drug costs for the year.



■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The UnitedHealthcare EPO Plan

The EPO Plan offers high-quality, cost-effective care through the Choice Network. You do not have to select a primary care provider (PCP), and you do not need a referral to see a specialist. However, you must receive care from providers within the Choice Network (except in emergencies, as described below).

Preventive services are covered 100% with no copayment. For non-preventive services, you pay copayments of only \$30 for visits to network primary care physicians (PCPs), \$50 for specialists and \$150 for the Emergency Room.

For in-patient hospital services and most other services, the plan pays 92% after you pay an annual deductible of \$350 for individual, or \$875 for family coverage.

Remember, there is no out-of-network coverage under this plan.

Special Circumstances

The following special circumstances can affect the benefits under the EPO Plan for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call UnitedHealthcare within 48 hours at **1-888-761-0337**. If you comply with these procedures, your copayment will be waived, and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.
- **You Must Pre-certify All Surgical or Major Diagnostic Procedures** — An exception is made when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call UnitedHealthcare at **1-888-761-0337** at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements for you.
- **If Your Dependent is a Student Away at School** — Under the EPO Plan, dependents may see Choice Network providers throughout the country. Simply call the number on the back of your card (**1-888-761-0337**), and a service representative will direct you to a network provider in the area. You can also search for an in-network provider by visiting www.myuhc.com.

Prescription Drug Benefits Provided by Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs will now count toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay \$10 for generic, \$30 for brand name and \$50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.
- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.
- **Mail-Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail-order program, you can receive up to a 90-day supply of medication. All you have to pay is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs.
- **Brand-Name Drugs** — If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand-name copay plus the difference in cost between the generic and brand-name.
- **Out-Of-Pocket Maximum** — Once you reach the prescription drug out-of-pocket maximum (\$1,500 per individual, or \$3,000 for a family), the plan pays 100% of any remaining prescription drug costs for the year.

■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

The UnitedHealthcare Consumer Directed Health Plan (CDHP) with a Health Savings Account (HSA)

The CDHP is designed for individuals and families who wish to plan for their health care needs over the long term. Its unique Health Savings Account (HSA) allows you to accumulate a substantial tax-free balance you can use to not only pay your eligible out-of-pocket costs for the current year (like deductible and coinsurance), but also save for future eligible expenses, such as health care in retirement.

To offer an HSA, plans like the CDHP must qualify under IRS rules as a “high-deductible health plan.” As a result, the deductible and out-of-pocket maximum in this plan are higher than in your other options. All non-preventive care (including prescription expenses) is subject to the deductible. If you elect this plan, HSS will make a contribution in 2021 to your HSA equal to half the in-network deductible.

If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network. To remain in network, you must receive care from a provider within the Choice Plus network.

■ **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no coinsurance. For non-preventive services, you pay an annual deductible of \$1,500 for individual coverage, or \$3,000 for family coverage. After you meet the deductible, eligible services will be covered as follows:

- All other eligible services (other than prescription drugs): The plan pays 80%, and you pay 20% up to the out-of-pocket maximum.
- Once you reach the out-of-pocket maximum (\$3,425 for individual coverage, or \$6,850 for family coverage), the plan pays 100% of any remaining costs for the year.
- In addition, your physician will submit your claims for reimbursement.

■ **Out-Of-Network** — If you choose an out-of-network provider, for most services the plan pays 60% after you satisfy an annual deductible (\$3,000 for individual coverage or \$6,000 for family coverage), until you reach the out-of-pocket maximum. Once you reach the out-of-pocket maximum (\$8,000 for individual coverage, or \$16,000 for family coverage), the plan pays 100% of any remaining costs for the year.

- You are responsible for filing claim forms no later than one year from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Understanding the Family Deductible and Out-of-Pocket Maximum

In the CDHP, the family deductible and out-of-pocket maximum work differently than they do in the other medical plans.

If you elect family coverage in the CDHP, the family deductible and out-of-pocket maximum apply to all covered family members individually *and* collectively. In other words:

- The plan does not begin paying benefits for *any* family member until the family deductible has been satisfied.
- The plan does not pay 100% benefits for any family member (other than for preventive) until the family out-of-pocket maximum has been met.



■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Prescription Drug Benefits Provided by Express Scripts

Under this plan, you pay the full amount for your prescription drugs until you reach the deductible, and then the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy.

- **In-Network Pharmacies** — Medications mandated under the Affordable Care Act are covered at 100%, with no deductible. For a list of these medications, as well as all covered medications, please log on to www.express-scripts.com. For all other medications, you pay the full price of all prescriptions until you reach the deductible. Once you reach the deductible, you pay a copayment of \$10 for generic, \$30 for brand name and \$50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.
- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy, even once you have satisfied your deductible.
- **Mail-Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail-order program, you can receive up to a 90-day supply of medication, but you will still pay the full cost of your prescriptions. Once you satisfy the deductible, all you have to pay is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs.
- **Brand-Name Drugs** — If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.

Health Savings Account (HSA)

Only the CDHP offers an HSA that:

- Includes contributions from HSS of up to \$750 for the year if you elect individual coverage and up to \$1,500 for the year if you elect family coverage. That's like having HSS pay half your deductible for 2021.
- Allows you to make optional pre-tax contributions to the account up to the following maximum:
 - Single Coverage: \$2,850 (additional \$1,000 if age 55+)
 - Family Coverage: \$5,700 (additional \$1,000 if age 55+)
- Offers a triple tax advantage: All money goes in tax-free, grows tax-free and remains tax-free when withdrawn to pay eligible expenses.
- Allows you to roll over unused balances from year to year. Unlike a Flexible Spending Account (FSA), there is no "use it or lose it" rule for the HSA. In fact, the money in your account remains yours if you change plans or leave the Company for any reason.

Review the [HSA section](#) of this Guide to learn more.



■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan**
- Pre-Admission Review
- Comparing Your Medical Options
- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional Health Choice Programs*

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The UnitedHealthcare Premium Plan

If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network. To remain in network, you must receive care from a provider within the Choice Plus network.

■ **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment. Eligible non-preventive services will be covered as follows:

- Physician services: The plan pays 100% after a \$30 copayment for Primary Care Physicians (PCPs) or specialists.
- Emergency Room visit: The plan pays 100% after a \$150 copayment.
- Inpatient hospital admission and most other eligible non-preventive services: The plan pays 100% after you pay an annual deductible of \$350 for individual coverage, or \$875 for family coverage.
- Other eligible services (other than prescription drugs): The plan pays 95%.
- Once you reach the out-of-pocket maximum (\$3,000 per individual, or \$6,000 for a family), the plan pays 100% of any remaining costs for the year.

In addition, your physician will submit your claims for reimbursement.

■ **Out-Of-Network** — If you choose an out-of-network provider, for most services, the plan pays 70% after you satisfy an annual deductible (\$600 per individual, or \$1,500 per family). You are responsible for filing claim forms no later than one year from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Once you reach the out-of-pocket maximum (\$5,000 per individual, or \$10,000 for a family), the plan pays 100% of any remaining costs for the year. However, you are still responsible for paying 100% of any amounts above the R&C limit an out-of-network provider may charge.



■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan**
- Pre-Admission Review
- Comparing Your Medical Options
- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional Health Choice Programs*

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Special Circumstances

The following special circumstances can affect the benefits under the Premium Plan for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call UnitedHealthcare within 48 hours at **1-888-761-0337**. If you comply with these procedures, you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.
- **When You're Away from Home** — If you're traveling and require emergency medical care, call the number on the back of your ID card, **1-888-761-0337**, and a service representative will direct you to a network provider in the area.
- **If Your Dependent is a Student Away at School** — Under this plan, dependents may see in- or out-of-network providers throughout the country. If you prefer to stay in-network, simply call the number on the back of your card (**1-888-761-0337**), and a service representative will direct you to a Choice Plus network provider in the area.



Prescription Drug Benefits Provided by Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs will now count toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay \$10 for generic, \$30 for brand name and \$50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.
- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.
- **Mail-Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail-order program, you can receive up to a 90-day supply of medication. All you have to pay is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs.
- **Brand-Name Drugs** — If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand-name copay plus the difference in cost between the generic and brand name.
- **Out-Of-Pocket Maximum** — Once you reach the prescription drug out-of-pocket maximum (\$1,500 per individual, or \$3,000 for a family), the plan pays 100% of any remaining prescription drug costs for the year.

Welcome To *Health Choice*

How *Health Choice* Works

■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Pre-Admission Review (All Medical Options)

Pre-Admission Review is a service that helps you determine both the necessity and duration of any inpatient hospital stay. The idea behind pre-admission review is to ensure that you receive the best possible medical care and to find out if any alternative treatments might be appropriate.

How Pre-Admission Review Works

You must call UnitedHealthcare at **1-888-761-0337** at least 48 hours before a scheduled admission and within 48 hours after an emergency admission to receive full benefits.



The Medical Plan

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review

Comparing Your Medical Options

- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional Health Choice Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Comparing Your Medical Options

The charts on the next pages highlight your medical options. Out-of-network benefit percentages (what the plan pays) under the Premium Plan and High Plan are based on reasonable and customary (R&C) expenses as described on [page 10](#).

Please note: The charts provide only a summary of medical benefits. The actual Summary Plan Description will be the governing document for the plan. The SPDs are available on the Benefits Administration website — www.hss.bswift.com — in the Library section. **Note:** The in-network benefits in the chart on the next pages assumes you do not use an HSS facility.

	CDHP with HSA		Premium Plan		High Plan		Low Plan (closed to new enrollees)		EPO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Annual Deductible	\$1,500 individual \$3,000 family ¹	\$3,000 individual \$6,000 family ¹	\$350 per individual \$875 per family	\$600 per individual \$1,500 per family	\$350 per individual \$875 per family	\$1,100 per individual \$2,750 per family	\$350 per individual \$875 per family	\$2,100 per individual \$5,250 per family	\$350 per individual \$875 per family
Annual Out-of-Pocket Limit (including copays, coinsurance and deductible)	\$3,425 individual \$6,850 family	\$8,000 individual \$16,000 family	\$3,000 per individual \$6,000 per family	\$5,000 per individual \$10,000 per family	\$2,000 per individual \$4,000 per family	\$4,000 per individual \$10,000 per family	\$2,000 per individual \$4,000 per family	\$5,000 per individual \$12,500 per family	\$3,000 per individual \$6,000 per family
Physician Office Visits (PCP/Specialist)	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100% after \$30/\$30 copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30/\$50 copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30/\$50 copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30/\$50 copayment
Virtual Visits	Plan pays 80%. You pay deductible plus 20%.	n/a	Plan pays 100% after \$10 copayment	n/a	Plan pays 100% after \$10 copayment	n/a	Plan pays 100% after \$10 copayment	n/a	Plan pays 100% after \$10 copayment
Hospitalization (including Surgeon's Fee)	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.
Emergency Room Treatment	Plan pays 80%. You pay deductible plus 20%.	Plan pays 80%. You pay deductible plus 20%.	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)	\$150 copayment (waived if admitted)
Well Adult Examination Preventative (19 years of age and older)	Plan pays 100%	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%
Well Woman Examination Preventative	Plan pays 100%	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%

¹ In the CDHP, the full family deductible must be met before the plan begins paying benefits for any family member.

Welcome To *Health Choice*

How *Health Choice* Works

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review

■ **Comparing Your Medical Options**

- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

	CDHP with HSA		Premium Plan		High Plan		Low Plan (closed to new enrollees)		EPO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Preventive Mammography Screening/PAP Smear	Plan pays 100%	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%
Well Child Exams & age appropriate immunizations & screenings	Plan pays 100%	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100%
Infertility Services Basic/Comprehensive Advanced (\$30,000 lifetime maximum benefit)	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Office visit: Plan pays 100% after \$30 copayment Outpatient visit: Plan pays 95%. You pay deductible plus 5%	Plan pays 70%. You pay deductible plus 30%.	Office visit: Plan pays 100% after \$30 or \$50 copayment/visit Outpatient visit: Plan pays 95%. You pay deductible plus 5%	Plan pays 70%. You pay deductible plus 30%.	Office visit: Plan pays 100% after \$30 or \$50 copayment/visit Outpatient visit: Plan pays 95%. You pay deductible plus 5%	Plan pays 70%. You pay deductible plus 30%.	Office visit: Plan pays 100% after \$30 or \$50 copayment/visit Outpatient visit: Plan pays 92%. You pay deductible plus 8%
Routine Nursery Physician Visits, Room & Board	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.
Second Surgical Opinion	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 100% after \$30 copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30 PCP/\$50 Specialist copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30 PCP/\$50 Specialist copayment	Plan pays 70%. You pay deductible plus 30%.	Plan pays 100% after \$30 PCP/\$50 Specialist copayment

Welcome To *Health Choice*

How *Health Choice* Works

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review

■ **Comparing Your Medical Options**

- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

	CDHP with HSA		Premium Plan		High Plan		Low Plan (closed to new enrollees)		EPO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Psychiatric Care									
Inpatient	Plan pays 80%. You pay deductible plus 20%	Plan pays 60%. You pay deductible plus 40%	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.
Outpatient	Plan pays 80%. You pay deductible plus 20%	Plan pays 60%. You pay deductible plus 40%	\$30 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment
Employer HSA funding	Up to \$750 for individual coverage; Up to \$1,500 for family coverage		n/a		n/a		n/a		n/a
Alcohol & Substance Abuse									
Inpatient Substance Use Disorders Treatment	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.
Outpatient Substance Use Disorders Treatment	Plan pays 80%. You pay deductible plus 20%	Plan pays 60%. You pay deductible plus 40%	\$30 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment	Plan pays 70%. You pay deductible plus 30%	\$50 copayment
Hospice Care¹									
Inpatient	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.
Outpatient	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay 5%. Not subject to deductible.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay 5%. Not subject to deductible.	Plan pays 70%. You pay deductible plus 30%.	\$50 copay
Home	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay 5%. Not subject to deductible.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay 5%. Not subject to deductible.	Plan pays 70%. You pay deductible plus 30%.	\$50 copay
Diagnostic X-ray	Plan pays 80%. You pay deductible plus 20%.	Plan pays 60%. You pay deductible plus 40%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 95%. You pay deductible plus 5%.	Plan pays 70%. You pay deductible plus 30%.	Plan pays 92%. You pay deductible plus 8%.

¹ There is a combined limit of 360 days per lifetime for Hospice Care.

Welcome To *Health Choice*

How *Health Choice* Works

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review

■ **Comparing Your Medical Options**

- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

	CDHP with HSA		Premium Plan		High Plan		Low Plan (closed to new enrollees)		EPO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Lab Service	Plan pays 80%. You pay deductible plus 20%	Plan pays 60%. You pay deductible plus 40%	Plan pays 95%. You pay deductible plus 5%	Plan pays 70%. You pay deductible plus 30%	No charge In-Network	Plan pays 70%. You pay deductible plus 30%	No charge In-Network	Plan pays 70%. You pay deductible plus 30%	No charge In-Network
Skilled Nursing Facility	Plan pays 80%. You pay deductible plus 20% for up to 60 days per calendar year ¹	Plan pays 60%. You pay deductible plus 40%	Plan pays 95%. You pay deductible plus 5% for up to 60 days per calendar year ¹	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay deductible plus 5% up to 30 days per year	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay deductible plus 5%; up to 30 days per year	Plan pays 70%. You pay deductible plus 30%	Plan pays 92%. You pay deductible plus 8% up to 30 days per year
Home Health Care	Plan pays 80%. You pay deductible plus 20% for up to 200 visits per calendar year	Plan pays 60%. You pay deductible plus 40%	Plan pays 95%. You pay deductible plus 5% for up to 200 visits per calendar year	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay 5% not subject to deductible	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay 5% not subject to deductible	Plan pays 70%. You pay deductible plus 30%	\$50 copayment for up to 60 visits per calendar year
Physical Therapy & Rehab									
Inpatient	Plan pays 80%. You pay deductible plus 20% for up to 60 days per calendar year ¹	Plan pays 60%. You pay deductible plus 40%	Plan pays 95%. You pay deductible plus 5% for up to 60 days per calendar year ¹	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay deductible plus 5% for up to 60 consecutive days per condition/per calendar year	Plan pays 70%. You pay deductible plus 30%	Plan pays 95%. You pay deductible plus 5%; up to 60 consecutive days per condition/per calendar year	Plan pays 70%. You pay deductible plus 30%	Plan pays 92%. You pay deductible plus 8% up to 60 consecutive days per condition/per calendar year
Outpatient	Plan pays 80%. You pay deductible plus 20% for up to 30 visits per calendar year	Plan pays 60%. You pay deductible plus 40%	\$30 copayment for up to 30 visits per calendar year	Plan pays 70%. You pay deductible plus 30%	\$50 copayment for up to 90 visits combined per calendar year	Plan pays 70%. You pay deductible plus 30%	\$50 copayment for up to 90 visits combined per calendar year	Plan pays 70%. You pay deductible plus 30%	\$50 copayment for up to 60 visits combined per calendar year

¹ Under the CDHP and Premium Plan, there is a combined limit on the number of days of skilled nursing facility and inpatient physical therapy.

Welcome To *Health Choice*

How *Health Choice* Works

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review
- Comparing Your Medical Options**
- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional Health Choice Programs*

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

	CDHP with HSA		Premium Plan		High Plan		Low Plan (closed to new enrollees)		EPO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Prescription Out-of-Pocket Maximum	Combined with medical	Combined with medical	\$1,500 individual ¹ \$3,000 family ¹		\$1,500 individual ¹ \$3,000 family ¹		\$1,500 individual ¹ \$3,000 family ¹		\$1,500 individual ¹ \$3,000 family ¹
Prescription Drugs (Express Scripts pharmacies only)									
Retail ²	After deductible is satisfied, \$10 copay for generic drugs, \$30 copay for brand-name drugs, \$50 copay for non-formulary drugs	Not covered	100% after \$10 copay for generic drugs, \$30 copay for brand-name drugs, \$50 copay for non-formulary drugs	Not covered	100% after \$10 copay for generic drugs, \$30 copay for brand-name drugs, \$50 copay for non-formulary drugs	Not covered	100% after \$10 copay for generic drugs, \$30 copay for brand-name drugs, \$50 copay for non-formulary drugs	Not covered	100% after \$10 copay for generic drugs, \$30 copay for brand-name drugs, \$50 copay for non-formulary drugs
Mail Order ² is 2.5x retail copay (up to 90-day supply)	Once deductible is satisfied, 100% after \$25 copay for generic drugs, \$75 copay for brand-name drugs, \$125 copay for non-formulary drugs	Not covered	100% after \$25 copay for generic drugs, \$75 copay for brand-name drugs, \$125 copay for non-formulary drugs	Not covered	100% after \$25 copay for generic drugs, \$75 copay for brand-name drugs, \$125 copay for non-formulary drugs	Not covered	100% after \$25 copay for generic drugs, \$75 copay for brand-name drugs, \$125 copay for non-formulary drugs	Not covered	100% after \$25 copay for generic drugs, \$75 copay for brand-name drugs, \$125 copay for non-formulary drugs
Lifetime Maximum	Unlimited								
Lifetime Infertility Prescription Drug Maximum	\$15,000								

¹ If enrolled in Family coverage; once a covered family member reaches the out-of-pocket maximum, cost is covered in full for that family member.

² If you purchase a brand-name drug when a generic equivalent is available, you will be responsible for the brand-name copay plus the difference in cost between the generic and brand-name.

Welcome To *Health Choice*

How *Health Choice* Works

■ **The Medical Plan**

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review
- Comparing Your Medical Options
- Coordination of Benefits
- Understanding Out-of-Network Costs
- Additional Health Choice Programs*

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Example—High-Cost Claim

The following example shows what you might pay for a high-cost claim.

This example assumes:

- You enroll in individual coverage
- All services are provided in-network at a non-HSS facility
- The total cost in the chart represents the plan-allowed fees for both hospital and physician expenses
- There were no other claims to date, so the in-network deductible had not previously been satisfied

High-Cost Claim — \$75,000

2020 Plan Designs	CDHP with HSA	Premium Plan	High Plan	Low Plan	EPO Plan
Total Cost	\$75,000	\$75,000	\$75,000	\$75,000	\$75,000
- Deductible	<u>- \$1,500</u>	<u>- \$350</u>	<u>- \$350</u>	<u>- \$350</u>	<u>- \$350</u>
Subtotal	\$73,500	\$74,650	\$74,650	\$74,650	\$74,650
Coinsurance (Your Share)	<u>x 20%</u>	<u>x 5%</u>	<u>x 5%</u>	<u>x 5%</u>	<u>x 8%</u>
	\$14,700	\$3,732	\$3,732	\$3,732	\$5,972
Deductible + Coinsurance	\$16,200*	\$4,082*	\$4,082*	\$4,082*	\$6,322
Out-of-Pocket Maximum	\$3,425	\$3,000	\$2,000	\$2,000	\$3,000
- HSA Contribution From HSS	- \$750	\$0	\$0	\$0	\$0
Your Net Cost	\$2,675	\$3,000	\$2,000	\$2,000	\$3,000

*Exceeds annual out-of-pocket maximum. Plan pays 100% of eligible expenses above this limit.

Welcome To *Health Choice*

How *Health Choice* Works

■ The Medical Plan

High Plan

Low Plan

EPO Plan

CDHP with HSA

Premium Plan

Pre-Admission Review

Comparing Your Medical Options

Coordination of Benefits

Understanding Out-of-Network Costs

Additional *Health Choice* Programs

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Coordination of Benefits

If you're covered under more than one health care plan, you may be paying for coverage you don't need. That's because of a provision known as "coordination of benefits," which applies to out-of-network coverage under the Premium Plan, High Plan and Low Plan.

With coordination of benefits, if you or one of your dependents is covered by more than one plan, the combined payments of both plans cannot exceed the amount HSS would normally pay if *Health Choice* was your only source of coverage. For example, if your spouse also has coverage under his or her employer's plan, any expenses he or she incurs must be submitted to the other plan first. If that plan pays 80% of the expenses, *Health Choice* will not pay any additional benefits. However, if your spouse's plan pays less than what *Health Choice* would normally pay, your HSS plan will pay the difference. There are no special coordination-of-benefit provisions for the EPO Plan, the MetLife DMO dental option, or for in-network coverage under the Premium Plan, High Plan or Low Plan. Refer to the Summary Plan Description (SPD) for further COB rules.

Understanding Out-Of-Network Costs

Under the Premium Plan and High Plan, benefits for out-of-network medical care are based on the plan's reasonable and customary (R&C) limit for each service. If a physician or other medical provider charges more than the R&C limits, you may be billed for the excess amount, along with your coinsurance percentage.

The plans use different measurements to set their R&C limit rates, which can mean different out-of-pocket costs for you.

- For the Premium Plan and High Plan, R&C limit is based on information from the Health Insurance Association of America, which surveys doctors every six months on their fees. The R&C limit is set at 80% of the range for your geographic area.
- All out-of-network claims must be submitted within six months of the date of service. Claims submitted late will be denied.

Notification Required for Certain Services

Notification is required before receiving certain covered health services. Network providers are responsible for this notification for in-network services. However, you are responsible for notification if you seek services from an out-of-network provider. If you do not provide this notification, you may be assessed a penalty charge when you seek any of the following:

- Ambulance
- Clinical Trials
- Congenital Heart Disease/Congenital Treatment at Centers of Excellence
- Transplantation Services/Transplantation Services at certain Designated Facilities
- Hospital – Inpatient Stay
- Chiropractic Services
- Outpatient Therapeutics Treatment
- Dental – Accident



Welcome To *Health Choice*

How *Health Choice* Works

■ The Medical Plan

- High Plan
- Low Plan
- EPO Plan
- CDHP with HSA
- Premium Plan
- Pre-Admission Review
- Comparing Your Medical Options
- Coordination of Benefits
- Understanding Out-of-Network Costs

[Additional Health Choice Programs](#)

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term
Disability Plan

The Life Insurance Plan

The Accidental Death &
Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online
Enrollment

Contacts

Additional Health Choice Programs

When you enroll in one of the UnitedHealthcare medical plans, you'll be eligible to participate in the following programs.

Advocate4Me

UHC's Advocate4Me program offers you a single point of contact (an advocate) at UHC who can provide you with end-to-end support on a variety of issues. When you call the customer care line at UHC, your advocate will answer your questions and remain on your case until all of your issues are resolved. Advocates can tap into a team of experts specializing in clinical care, emotional health, pharmacy, health care costs and medical plan benefits to help you navigate the health system and get the information you need. To reach Advocate4Me, call the member number listed on your health plan ID card or log on to myuhc.com® and click the "Call or Chat" button.

UnitedHealthcare Mobile App

This UnitedHealthcare app features many of the services that are available at myuhc.com. The app is free and is easy to download and use.

Virtual Visits

When you need care—anytime day or night—Virtual Visits can be a great option. Connect with a doctor online to discuss illnesses including allergies, migraines, fevers and colds. With Virtual Visits you can:

- Video chat with a doctor on your mobile device, tablet or computer
- Get a prescription if needed

To find out more about Virtual Visits, go to uhc.com/virtualvisits.

UHC 24-Hour Nurseline

With 24-Nurseline, you can get advice from a registered nurse anytime – 24 hours a day, 7 days a week. They're available to answer questions related, for example, to a child's fever, side effects of medications and managing health conditions like diabetes. 24-Hour Nurseline can help you:

- Decide when to visit your doctor, or go to an Urgent Care Facility or Emergency Room
- Find network doctors and schedule appointments
- Understand your medications and how to take them safely
- Learn about checkups or preventive care

It's simple, there's no additional cost—and it can give you the peace of mind you need. Call 1-800-401-7396 to talk with a nurse about your health questions.

Prescription Drug Coverage

With our Health Choice medical plans, you receive prescription drug benefits administered by Express Scripts.

Under all plans except the CDHP with HSA:

- All drugs have a copay but are not subject to the healthcare deductible

Under the CDHP with HSA:

- You are responsible for paying your prescription drug expenses until you satisfy the healthcare deductible. Then you will pay a percentage of the costs

Save Money on Prescription Drugs

There are three types of prescription drug categories:

- Generic (least expensive)
- Brand-name drug on the plan's preferred list (more expensive)
- Non-formulary drug (most expensive)

When a generic drug is available and the preferred or non-preferred brand is purchased, you will pay the applicable brand coinsurance plus the difference in cost between the brand and the generic. Be sure to ask your doctor to prescribe a generic drug whenever it is appropriate.

If you take a medication regularly for a condition such as high blood pressure or diabetes, you can save money by purchasing up to a 90-day supply of those medications through Express Scripts mail order. Using Express Scripts mail order is convenient and helps avoid paying more for your prescriptions. If you choose to purchase your maintenance medications at a retail pharmacy, the cost for a 30-day supply will increase after the second fill at your local pharmacy.

Prescription Drug Coverage Changes

Prescription drugs are vital to good health care, but are increasingly complex and expensive, requiring careful management to protect your health. Beginning January 1, 2021, we are offering these additional prescription program at no cost to you:

- **Pulmonary Care Value Program:** Remote monitoring system to track adherence to pulmonary medications and live member outreach for additional education.

- **Diabetes Care Value Programs:** Free connected glucose monitor & scale Helps eligible members monitor blood sugar & shares values with providers to provide better clinical care;

Preferred Drug Step Therapy

A Preferred Drug Step Therapy program is a “step” approach to providing prescription drug coverage. Preferred Drug Step Therapy is designed to encourage the use of cost-effective prescription drugs when appropriate. To determine if your prescription requires Preferred Drug Step Therapy, or is subject to limitations, call Express Scripts at 1-800-818-0093.

If you have a discontinuance or lapse in therapy of more than 130 days while using the brand-name medication and need to restart therapy, you will be subject to another review under the Preferred Drug Step Therapy program to determine if the cost of the brand-name medication will be covered under the Plan. There is no minimum age requirement for Step Therapy.

The preferred method to request an initial clinical coverage review is for the prescriber or dispensing pharmacist to call the Express Scripts Coverage Review Department at 1-800-753-2851.

Maintenance Medications (Smart 90 Program)

You are allowed up to two fills (30-day supply each) for maintenance medications (such as high blood pressure or diabetes medications) at any in-network retail pharmacy. On the third fill, you must fill a 90-day supply of the medication through one of these pharmacies:

- CVS/Walgreens (including Duane Reade), or
- Mail-order through Express Scripts Pharmacy

Your cost for mail-order prescriptions is \$25 for generic, \$75 for brand name and \$125 for non-formulary drugs. If you continue filling a 30-day supply instead of a 90-day supply—or if you're using a non-participating pharmacy—you'll pay the full cost for your medicine.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

■ The Dental Plan

The MetLife Traditional Option

The MetLife Optional Voluntary Plan

The MetLife DMO Option

Pre-Determination of Benefits

The No Coverage Option

Comparing Your Dental Options

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Dental Plan

Unlike most medical expenses, dental expenses are fairly predictable and rarely catastrophic. At the same time, however, dental expenses can add up quickly, especially when routine care is neglected. That's why the *Health Choice* Dental Plan is designed to help you and your family take care of your routine dental needs while also ensuring that you're covered for more serious dental expenses.

Health Choice offers three dental options that cover the same types of services but have different deductibles, different benefit maximums and different restrictions on which dentists you can see. You can also waive dental coverage entirely, if you prefer.

The MetLife Traditional Option

The MetLife Traditional Option is designed for people who want the freedom to visit any dentist they choose. This option has a lower premium when compared with the Optional Voluntary Dental Plan, but has a lower annual benefit of \$1,850.

The MetLife Optional Voluntary Plan

The MetLife Optional Voluntary Dental Plan is designed for people who want the freedom to visit any dentist they choose. This option has higher premiums when compared with the Traditional Option, but has an increased annual benefit of \$3,250.

How the MetLife Traditional and Optional Voluntary Dental Plans Work

Under the two MetLife dental plan options, you decide whether to see a network dentist or a non-network dentist. Usually you pay less when you see a network dentist because these dentists agree to charge lower fees for their services. Regardless of whether you see a network or non-network dentist, each covered individual must pay a deductible before receiving benefits for Basic, Major and Orthodontia Services. The deductible is waived for Diagnostic and Preventive Services.

■ The annual deductible is:

- \$50 if you see an in-network dentist (deductible is waived for in-network preventive care)
- \$100 if you see an out-of-network dentist
- After the deductible has been met, the plan pays benefits based on the type of dental services received

■ **Diagnostic and Preventive Services** — Both plans pay 80% of eligible expenses for oral exams, emergency treatment for pain, and bitewing X-rays twice a year, six months apart, as well as other routine diagnostic and preventive services.

■ **Basic Services** — Both plans pay 80% of eligible expenses for basic dental services such as fillings, extractions, gum surgery and root canals.

■ **Major Services** — Both plans pay 50% of eligible expenses for major dental services such as dentures, bridges and crowns.

■ **Orthodontia Services** — The plan pays 50% of eligible expenses for orthodontia services such as appliances and orthodontic X-rays.

Maximum Benefits

The MetLife Traditional Option has a \$1,850 annual benefit for each individual enrolled. The MetLife Optional Voluntary Plan has a \$3,250 annual benefit for each individual enrolled. Both plans offer a \$1,000 per lifetime orthodontia benefit for each covered individual.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

■ The Dental Plan

The MetLife Traditional Option

The MetLife Optional Voluntary Plan

The MetLife DMO Option

Pre-determination of Benefits

The No Coverage Option

Comparing Your Dental Options

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The MetLife DMO Option

The MetLife DMO is a Dental Maintenance Organization (DMO) that offers quality dental care at a low cost through a network of participating dentists. The MetLife DMO is only offered in the following states: New York, New Jersey, Florida, California, & Texas.

How the MetLife DMO Works

If you elect coverage under the MetLife DMO, you must select a primary care dentist from a network of providers. If you don't, you will be assigned one (based on your home Zip code) by MetLife. Once you receive your dental ID card you will need to contact MetLife if you wish to select a different primary care dentist. Then, whenever you need dental care, your treatment must be coordinated by the MetLife dentist you selected. When you use your MetLife dentist, there are no deductibles to pay, no annual benefit maximums and no claim forms to file. In fact, many of your basic dental services will be provided to you at no charge whatsoever. Other services will require reasonable specified copayments. On the other hand, if you receive care from a non-participating dentist, you will not be eligible for any benefits at all.

■ There is no annual deductible.

■ **Diagnostic and Preventive Services** —The plan pays 100% of eligible expenses for oral exams, emergency treatment for pain, and bitewing X-rays twice a year, six months apart, as well as other routine diagnostic and preventive services.

■ **Basic Services** — Basic services include fillings, root canals. For information regarding the cost of your Copays by procedure type, please reference the complete schedule of benefits.

■ **Orthodontia Services** — The plan covers eligible expenses for orthodontia services such as appliances and orthodontic X-rays.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

■ The Dental Plan

The MetLife Traditional Option

The MetLife Optional Voluntary Plan

The MetLife DMO Option

Pre-determination of Benefits

The No Coverage Option

Comparing Your Dental Options

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Pre-Determination of Benefits

If you see a network dentist there is no need to file for pre-determination of benefits. However, if you see a non-network dentist and your dental treatment under the Traditional option is expected to cost more than \$300, it is recommended that you file for a pre-determination of benefits before the work begins. That way, you can find out in advance how much the plan will pay. You may also find out if another course of treatment might be more cost-effective. To receive a pre-determination of benefits, simply ask your dentist to fill out a claim form and check the box indicating you want an estimate of your benefits. You'll receive a notice of whether the treatment is covered and how much the plan will pay.

The No Coverage Option

If you prefer, you can also waive your *Health Choice* dental coverage entirely.

Comparing Your Dental Options

The following chart highlights your dental options. Benefit percentages under the Traditional option are based on reasonable and customary expenses as described on [page 10](#). However, if you use a network dentist, benefit percentages are based on pre-negotiated fees that are usually below the reasonable and customary expenses.

	MetLife DMO	MetLife Traditional	MetLife Optional Voluntary
Annual Deductible	None	In-network: \$50 per individual Out-of-network: \$100 per individual	In-network: \$50 per individual Out-of-network: \$100 per individual
Preventive Services*	100%	80% with no deductible (in-network)	80% with no deductible (in-network)
Diagnostic Services	Scheduled	80% after deductible	80% after deductible
Basic Services	Scheduled	80% after deductible	80% after deductible
Major Services	Scheduled	50% after deductible	50% after deductible
Orthodontia Services	Scheduled	50% after deductible; \$1,000 lifetime maximum per individual	50% after deductible; \$1,000 lifetime maximum per individual
Annual Benefit Maximum	None	\$1,850 per individual	\$3,250 per individual

* Twice a year, six months apart, cleanings only.

This is only a summary of dental benefits. The actual Summary Plan Description will be the governing document for the plan.

Things to Consider

Under *Health Choice*, your dental plan is a separate choice from your medical plan. In other words, you can enroll for a medical plan, a dental plan, both or neither.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

■ The Vision Plan

How The Vision Plan Works

Pre-Determination of Benefits

Other Services

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Vision Plan

Hospital for Special Surgery believes good eyesight is an important part of your overall health, which is why a Vision Plan is included among your *Health Choice* benefits options. It is not necessary to enroll in either a medical or dental plan to enroll in the Vision Plan.

The Vision Plan is offered by Guardian, one of the nation's leading administrators of vision-care programs.

How the Vision Plan Works

The Vision Plan is a PPO. You enjoy a higher level of benefits for services received at in-network vision-care providers, including Davis Vision, Walmart, Sam's Club, Target, Sears, JCPenney and Pearle. Basic services, such as examinations and most eyewear purchases, are covered in full after a \$10 copayment.

You may choose your eyewear, including spectacles and frames, from a list of pre-approved products. If you choose a frame not included on the pre-approved list, you will receive a credit of up to \$130, plus a 20% discount, toward the purchase of that frame. You must pay the difference. Contact lenses are also available. You pay the \$10 copayment for standard models or receive a credit of up to \$130 for non-standard models, plus a 15% discount toward the purchase of the contact lenses.

Your benefits decrease at out-of-network providers. You must pay the provider up front and then file a claim with Guardian for reimbursement.

Pre-Determination of Benefits

To arrange services, call the in-network provider of your choice and schedule an appointment. Tell him or her at that time that you're a member of the Vision Plan through the Hospital for Special Surgery. You also need to give the provider your participant's ID number and the name and birthdate of any covered dependents to receive services. The provider will pre-determine your benefit with Guardian. You won't need to file any claims paperwork.



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

■ The Vision Plan

How The Vision Plan Works

Pre-Determination of Benefits

Other Services

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Other Services

The Vision Plan covers a wide variety of spectacles, frames and contact lenses, including mail-order contact lenses. The plan also offers discounts to eligible members for laser vision correction services. Please visit the Guardian website or call their customer service number for more details.

Overview of Services	In-Network	Non-Network *	Frequency
Routine Eye Exam	\$10 copay	Up to \$50	Once every calendar year
Glasses			
• Frames Allowance	Collection up to \$160; Other up to \$130 plus 20% off balance	Up to \$48	Once every calendar year
• Single Vision Lenses	\$10 copay	Up to \$48	Once every calendar year
• Bifocal Lenses (Lined)	\$10 copay	Up to \$67	Once every calendar year
• Trifocal Lenses (Lined)	\$10 copay	Up to \$86	Once every calendar year
• Included Lens Options	Fashion or gradient tinting of plastic lenses 1 Year Breakage Guarantee		
Contact Lenses (In Lieu of Glasses)**			
• Medically Necessary	Covered in Full	Up to \$210	Once every calendar year
• Elective	\$130 max +15% off balance	Up to \$105	Once every calendar year

**You must pay up front for services from out-of-network providers and then file a claim for reimbursement.*

***Once fitted and purchased, contact lenses may not be exchanged for eyeglasses.*

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

■ **The Long-Term Disability Plan**

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Long-Term Disability Plan

Long-term disability (LTD) coverage protects you and your family financially if a serious illness or injury prevents you from working for an extended period of time. The plan begins to pay benefits after you've been disabled for 26 consecutive weeks. You must be a regular full-time employee to be eligible for LTD coverage. If you have not yet enrolled in Voluntary LTD coverage, you can do so during open enrollment.

Following your enrollment, you will be sent to The Hartford website to complete the Personal Health Application. Should The Hartford approve your application, you will receive notification of the coverage effective date. If you don't complete the Personal Health Application your request for coverage will be denied. **Note: This plan is not available to part-time employees.**

How the LTD Plan Works

Health Choice offers two types of LTD coverage.

- **Basic** — If you are eligible for LTD coverage, you will be automatically enrolled in the Basic LTD Plan. Basic LTD coverage replaces 60% of your monthly salary, with a maximum monthly benefit of \$1,200. HSS pays the full cost of your Basic LTD coverage.
- **Voluntary** — If you earn more than \$23,000 per year, you can increase your LTD coverage amount. Voluntary LTD coverage also replaces 60% of your monthly salary above \$24,000, but with a maximum monthly benefit of \$13,800. The cost of the Voluntary LTD coverage will be presented in the Voluntary LTD enrollment page on the *Health Choice* online enrollment site.

How Your Benefits Are Calculated

Let's assume you earn \$22,000 per year. That means your basic monthly earnings are \$1,916 (\$22,000 divided by 12). If you are totally disabled for more than 26 weeks, your monthly LTD benefit will be \$1,150 (60% of \$1,916), reduced by payments from other sources as outlined in "Things to Consider."

Note: Benefits for the portion of Voluntary LTD coverage that you pay for will be tax-free.

How Your Cost Is Calculated

The Hospital pays the entire cost of the basic LTD benefit of \$1,150. If you elect additional Voluntary LTD coverage, your cost will be based on your age and your annual salary.

Duration of Benefits

Benefits normally last until you recover, or until you reach age 65 or your Social Security Normal Retirement Age, whichever comes first. However, if you become disabled at age 63 or older, the maximum benefit period will be determined as shown below:

Age at Disability	Maximum Benefit Period
Younger than 63	To Social Security Normal Retirement Age* or 42 months, whichever is longer
63	To Social Security Normal Retirement Age* or 36 months, whichever is longer
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

* Social Security Normal Retirement Age is determined by the rules of the United States Social Security Act (as revised in 1983). It is determined by your birth year. For example, if you were born in the years 1943 - 1954, your Social Security Normal Retirement Age is 66 years old.

Things to Consider

Under *Health Choice*, your monthly LTD benefit will be reduced by any payments you receive from other sources, such as Social Security and Workers' Compensation. This means that if your monthly LTD benefit is \$1,200 and you receive \$400 from other sources, the *Health Choice* LTD Plan will pay \$800, bringing your total benefit to \$1,200.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

■ **The Life Insurance Plan**

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Life Insurance Plan

The *Health Choice* Life Insurance Plan helps protect your family’s financial future if you die. The amount of your coverage depends on the life insurance option you elect. All HSS regular employees must be covered by a life insurance option.

How the Life Insurance Plan Works

Health Choice offers multiple levels of coverage. As a new hire, you'll receive Basic coverage equal to your annual salary. Plus, you may elect Additional coverage as a multiple of your salary, 1x, 2x, 3x, 4x, 5x, not to exceed 5 times your salary. The maximum combined Basic and Additional benefit is \$1,500,000. The price for each option is based on your age and salary. The cost for basic coverage will be paid in full by HSS.

During your new hire enrollment period the guaranteed issue amount (combined basic and voluntary election is 5 times your salary, not to exceed \$1,000,000.

The following chart outlines your life insurance coverage levels:

Life Insurance Coverage Level Options
Basic: 1x salary
Additional: Multiple of your salary 1x to 5xs

How Your Benefits Are Calculated

If you earn \$50,000 a year and select \$60,000 in Additional coverage, your total life insurance coverage amount will equal \$110,000 (\$50,000 + \$60,000). If your Basic coverage amount is not a round number, it will be rounded up to the next highest multiple of \$1,000.

How Your Cost Is Calculated

The Hospital pays the full cost of Basic life insurance coverage equal to one times your annual salary. If you elect voluntary Additional coverage, your cost will be based on your age and the amount of Additional coverage you elect.

Increasing Your Coverage

You have the option of increasing your coverage during open enrollment. Following completion of enrollment, you will be sent to The Hartford website to complete the Personal Health Application. Should The Hartford approve your application, you will receive notification of the coverage effective date. If you don’t complete the Personal Health Application, your request for coverage will be denied.

Reduction in Benefits Due to Age

If you are age 70 or older, your life insurance coverage is reduced to 50% of the original amount.

Naming Your Beneficiaries

Your beneficiaries are the people who will receive payment from the plan if you die. You can name your beneficiaries on the online Benefits Administration website.

How Benefits Are Paid to Your Beneficiaries

If you die while covered by the plan, benefits will be paid to your beneficiaries in a single lump-sum payment. If any of your primary beneficiaries are no longer living, your life insurance benefits will be divided equally among your remaining beneficiaries. If all of your primary beneficiaries are no longer living, your life insurance benefits will be divided equally among your contingent beneficiaries, unless otherwise specified.

Changing Your Beneficiaries

Because your family situation is always subject to change, you’re free to change your life insurance and accidental death & dismemberment beneficiaries at any time. You can change your beneficiaries through the Benefits Administration website at www.hss.bswift.com.

Tax Considerations

If your annual salary is more than \$50,000, any amount of Basic (hospital-paid) life insurance coverage in excess of \$50,000 is considered imputed income by the IRS. Imputed income is considered taxable income, just like your regular pay. It is shown on your biweekly pay stub and will be included as taxable income on your W-2 form.

Welcome To Health Choice

How Health Choice Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Accidental Death & Dismemberment Plan

The Health Choice Accidental Death & Dismemberment (AD&D) Plan provides an additional way to protect you and your family financially. Benefits are paid if you die in an accident or are seriously injured in an accident (seriously injured means you suffer the loss of sight, hearing, speech, or a limb).

How the AD&D Plan Works

Health Choice offers multiple levels of coverage. You'll receive Basic coverage equal to \$50,000. Plus, you may elect Additional coverage in multiple of your salary (1x to 5xs), not to exceed 5 times your salary. The maximum combined Basic and Additional benefit is \$1,500,000. The price for each option is based on your age and salary. The cost for basic coverage will be paid in full by HSS.

The following chart outlines your AD&D insurance coverage levels:

AD&D Coverage Level Options
Basic: \$50,000
Additional: Multiple of your salary 1x to 5xs



Reduction in Benefits Due to Age

If you are age 70 or older, your AD&D coverage is reduced to 50% of the original amount.

How Your Benefits Are Calculated

If you die in an accident, your designated beneficiaries will receive 100% of your coverage amount. If you are seriously injured in an accident, the plan will pay benefits based on the following schedule:

If You Lose	The Plan Pays
Your Speech and Hearing	100% of your coverage amount
Sight in Both Eyes	100% of your coverage amount
One Hand and One Foot	100% of your coverage amount
Both Hands or Both Feet	100% of your coverage amount
Sight in One Eye, and Lose One Hand or One Foot	100% of your coverage amount
One Foot or One Hand	50% of your coverage amount
Sight in One Eye	50% of your coverage amount
Thumb and Index Finger on Same Hand	25% of your coverage amount

Benefits for serious injuries will be paid directly to you, not to your beneficiaries. To be eligible for benefits, the loss must occur within one year of an accident and be directly caused by that accident.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

■ The Health Savings Account

Eligibility

Contributions

General Rule

Using Your HSA Contributions

Eligible Expenses

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Health Savings Account

The Health Savings Account (HSA) is a special tax-advantaged savings account offered **only to participants in the Consumer Directed Health Plan (CDHP)**. You can use your HSA to offset out-of-pocket health care costs this year, or save it for the future.

An HSA is similar in some ways to a Flexible Spending Account but with some important differences. Here are the key features:

- **A triple tax advantage.** HSA money is tax-free when it enters the plan and when it grows through investment earnings. And it remains tax-free when it is withdrawn — as long as you use it to pay eligible health care expenses .
- **Immediate ownership.** All contributions to your HSA, including contributions from HSS, are immediately yours to keep.
- **No risk of forfeiture.** Any unused amount at the end of a plan year rolls over to the next year. Unlike a Flexible Spending Account, there is no “use it or lose it” rule.
- **Portability.** If you change plans, retire or leave HSS for any reason, you keep your account balance.
- **Investment options.** Once you reach a certain balance in your HSA, you can choose from the account’s options for investing your balance. Interest and investment earnings are also tax-free. **If you elect the CDHP contact the HSA bank (Optum Bank) at 1-800-791-9361 for details.**
- **Easy withdrawals.** Your HSA is your own personal account. Unlike an FSA, you do not have to file a claim for reimbursement.

Eligibility

To contribute to the HSA, you must be covered by the CDHP through HSS. You may not contribute to an HSA if you:

- Can be claimed as a tax dependent of another individual
- Are entitled to Medicare
- Have medical plan coverage other than a high-deductible health plan, including coverage under your spouse or domestic partner’s plan or a Health Care Spending Account

See IRS Publication 969 at www.IRS.gov/publications for additional information.



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

■ The Health Savings Account

Eligibility

Contributions

General Rule

Using Your HSA Contributions

Eligible Expenses

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Contributions

In order to receive the HSS contribution and to have your voluntary contribution deposited to your account, **you must first open a bank account with Optum Bank**. As part of the enrollment process you will be presented with the Optum Bank site link.

For 2021, HSS will contribute:

- \$31.25 semi-monthly (up to \$750) if you elect individual coverage.
- \$62.50 semi-monthly (up to \$1,500) if you elect family coverage.

HSS contributions begin as of your benefits effective date.

***You must be employed and enrolled in the CDHP and have an active HSA bank account with Optum Bank in order to receive the HSS contribution.**

If you make optional contributions yourself, the maximum annual pre-tax amount you and HSS combined can contribute to your account is determined by the IRS, as follows:

Coverage Level	IRS Combined Maximum for 2021	HSS Contribution for 2021	Amount You Can Contribute for 2021*
Individual	\$3,600	\$750	\$2,850
Family	\$7,200	\$1,500	\$5,700

**If you are age 55 and older in 2020, you may make an additional catch-up contribution of up to \$1,000 per year.*

General Rule

As a general rule, your annual HSA contribution limit is determined by your HSA eligibility date and coverage tier (“individual” or “family”). If you have enrolled in the HSA plan after January 1, your annual contribution limit will be prorated based on the number of months remaining in the current year.

For example, if you are enrolled in the CDHP family coverage tier:

- Effective January 1, you are eligible to contribute up to the full annual IRS maximum of \$5,700 to your HSA (or \$475/month)
- Effective March 1st, you are eligible to contribute up to \$4,750 (\$5,700/12*10) to your HSA
- Effective March 2 - 31, *your HSA eligibility begins the first of the next month (April 1)*; therefore, you can contribute up to \$4,275 (\$5,700/12*9) to your HSA

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

■ The Health Savings Account

Eligibility

Contributions

General Rule

Using Your HSA Contributions

Eligible Expenses

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Using Your HSA

Accessing HSA funds is easy. Within 7-10 days of opening your account, you'll receive a Debit MasterCard from Optum Bank by mail. Once you activate your card, you can use it to pay for doctor's office visits at the time of the appointment or for qualified items at the pharmacy or other retailer.

Eligible Expenses

The IRS determines what expenses qualify for reimbursement from an HSA. Eligible expenses include:

- Deductibles and coinsurance
- Prescribed medications
- Mental health specialist visits and prescriptions
- Ambulance service, chiropractor, X-rays
- Dental cleaning, sealants, fluoride treatments, extractions, orthodontia
- Eye exams, contact lenses, eyeglasses, eye surgery

See IRS Publications 502 and 969 at www.IRS.gov/publications for information about eligible HSA expenses.

IMPORTANT – No double dipping! Health care expenses reimbursed from your HSA cannot be reimbursed from your spouse's pre-tax reimbursement plan or program. IRS rules do not allow you to be reimbursed for expenses through an HSA for non-tax-qualified dependents. For example, if you enroll a domestic partner in the High-Deductible Health Plan, he/she must be a tax-qualified dependent in order to have his/her expenses reimbursed through an HSA. We suggest that you seek guidance from your personal tax advisor to confirm the eligibility of any dependents for whom you plan to submit HSA expenses.

Contributions Less Than the Full Monthly Amount by Month

If you are enrolled in *individual* CDHP coverage on the first day of any month, you may contribute up to the \$237.50 pre-tax limit for that month.

If you are enrolled in *family* CDHP coverage on the first day of any month, you may contribute up to the \$475.00 pre-tax limit for that month.

If you contribute less than the full monthly amount in any month, you may be able to make up the difference by making a contribution directly to Optum Bank. For example, assume you enrolled in individual coverage for the entire year and you elect to contribute \$100 each semi-monthly pay period. HSS will contribute \$750 for the year and you will have contributed \$2,400, for a combined annual total of \$3,150. The IRS maximum for 2021 is \$3,600, so you may contribute an additional \$450 *directly to Optum Bank no later than the original filing due date (without extensions) for your tax return (April 15, 2022).*

December 1/Full-Year Contribution Rule

If you became a participant in the CDHP after January 1, and remain HSA-eligible as of December 1 of that tax year, then you are considered HSA-eligible *for the entire calendar year and are therefore permitted to make the full-year voluntary contribution by making a payment directly to Optum Bank to your HSA.* Your CDHP coverage tier ("individual" or "family") in effect on December 1 governs your HSA contribution limit for that year. If you want to take advantage of the full-year contribution rule, *you will have to remain in the CDHP through December 31 of the next year.* If you have a change that makes you no longer HSA-eligible, you risk adverse tax consequences and should consult a tax professional.

This rule affects anyone who:

- Becomes HSA-eligible after January 1, or
- Has been HSA-eligible for the entire year but changes his or her CDHP coverage tier during the year

For example, if you are enrolled in the CDHP effective March 1, 2021, and you want to take advantage of the full contribution rule, you would have to remain in the CDHP until December 31, 2022.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

■ The Flexible Spending Accounts

How The Flexible Spending Accounts Work

Your Dependents

Eligible Expenses

Flexible Spending Account Worksheets

Your Best Tax Advantage

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

The Flexible Spending Accounts

The Flexible Spending Accounts (FSAs) help you stretch your health care and dependent care budgets. That's because these accounts let you use tax-free dollars to pay for eligible health care and dependent care expenses.

The money you contribute to the FSAs is free of federal income, Social Security, and New York State and city taxes. You don't pay tax on the money you deposit in the accounts, and you don't pay tax on the reimbursements you receive from your account.

How the Flexible Spending Accounts Work

There are two separate FSAs: the Health Care Spending Account and the Dependent Care Spending Account (for eligible child care expenses). You may choose to participate in one, both or neither account. Your participation in the Flexible Spending Accounts is voluntary and funded entirely by you. As with all your other *Health Choice* benefits, your participation will start on your benefits effective date and end on December 31, unless you have a qualifying change in life status (see [pages 6 and 7, Changing Your Coverage](#)).

Your Dependents

For the purposes of the Health Care Spending Account, your dependents are your spouse, your children or anyone else you claim as a dependent on your tax return.

For the purposes of the Dependent Care Spending Account, your **qualified dependents are your children 12 and under or any dependent who is physically or mentally incapable of caring for himself or herself**, as long as you claim them as dependents on your tax return. Eligible expenses must be incurred prior to your dependent child turning age 13.



FSA Enrollment

Your FSA enrollment does not automatically renew from year to year. Regardless of your past participation, you must re-enroll for 2021 to participate.

Rules to Remember

Please note that the following IRS rules apply to FSAs:

- Estimate carefully! **The election you make is in effect all year, unless you have a qualifying change in life status.** What's more, any money left in either account at the end of the year will be forfeited. Use it or lose it!
- Health Care and Dependent Care Spending Accounts have different eligible expenses. See the worksheets on [pages 45 and 47](#) for a partial list.
- You may not transfer money between accounts.
- No double dipping! Health care expenses can be reimbursed from the Health Care Spending Account or claimed as a federal tax deduction — not both. The same is true for dependent care expenses. Please see [page 47](#) for more detailed information on taxes and the Dependent Care Spending Account. Health care expenses reimbursed from your Health Care Spending Account cannot be reimbursed from your spouse's pre-tax reimbursement plan or program.
- No double dipping! Health care expenses reimbursed from your HSA cannot be reimbursed from your spouse's pre-tax reimbursement plan or program.
- You must include your dependent care provider's Social Security or tax ID number on your claim forms. If you do not have this number, your claims will not be reimbursed.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

■ The Flexible Spending Accounts

How The Flexible Spending Accounts Work

Your Dependents

Eligible Expenses

Flexible Spending Account Worksheets

Your Best Tax Advantage

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Eligible Expenses

The worksheets on the next page contain a partial listing of eligible expenses. To participate in the FSAs:

- **Estimate your expenses** — Using the worksheets on the next page, figure out what your unreimbursed medical expenses and your dependent care expenses will be for the coming year.
- **Decide on your deposit and complete your enrollment form** — The plan limits the amount you can contribute to the Health Care Spending Account to \$2,750 a year. The IRS limit for the Dependent Care Spending Account is \$5,000* a year if single or married and filing a joint tax return, or \$2,500 if married and filing an individual return. The minimum you can contribute to either account is \$100 per year. Special limits apply if you are married; see [page 46](#) for more information. ***Important: If you are a highly compensated employee as defined by the IRS and participate in the Dependent Care FSA, it may be necessary for your HSS to decrease your annual election amount based on required federal testing of the Dependent Care FSA to ensure that the Dependent Care FSA does not discriminate in favor of highly compensated employees.**
- **File your claim** — When you have expenses, you have two options for reimbursement. The first is to use the debit card you received from the FSA administrator (Ultra Benefits). This debit card can be used for both the Healthcare FSA and the Dependent Care FSA. The second option is to pay the provider as you normally would. Then submit the receipt, along with a completed claim form (available on the Benefits Administration website — www.hss.bswift.com) to the FSA administrator at the address listed on the form. You have until March 31 of the following year to file claims for expenses incurred during the plan year. **If you are currently enrolled in an FSA Plan, make sure to check the expiration date on your Benny Card. The card will be valid up to that expiration and your new election will be added to that card.** If you leave HSS during the year, your occurred eligible expenses must have prior to your termination date.
Note: The FSA Administrator will charge a fee if you request a replacement debit card.
- **Receive your reimbursement** — You will receive a reimbursement check from the FSA administrator.



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

■ The Flexible Spending Accounts

How The Flexible Spending Accounts Work

Your Dependents

Eligible Expenses

Flexible Spending Account Worksheets

Your Best Tax Advantage

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Flexible Spending Account Worksheets

Use the worksheets in this section to estimate what your health care and dependent care expenses will be for the year. This will help you determine how much you should deposit into the FSAs.

Your FSA enrollment does not automatically renew from year to year. Regardless of your past participation, you must re-enroll for 2021 to participate.

Health Care Spending Account Worksheet

Your Health Care Expenses (maximum annual contribution: \$2,750)	Estimated Costs
Medical plan deductibles	\$
Amounts not paid by any medical plan (such as copayments and coinsurance)	\$
Amounts for medical services above R&C	\$
Other non-reimbursable medical expenses (such as private hospital rooms, nursing services and acupuncture, etc.)	\$
Dental plan deductibles	\$
Amounts not paid by any dental plan (including copayments, coinsurance, and orthodontic expenses over plan limits)	\$
Amounts for dental services above R&C	\$
Other non-reimbursable dental expenses	\$
Vision care expenses (such as for exams, contact lenses, frames and lenses)	\$
Hearing care expenses (such as for exams and hearing aids)	\$
Your Total Estimated Health Care Expenses	\$

You, your spouse, your children or anyone else you claim as a dependent on your tax return may incur these expenses, regardless of whether they are covered under a *Health Choice* medical or dental option. If you have questions or concerns about the eligibility of certain medical expenses, you may wish to consult a tax advisor.

Please call Ultra Benefits, the FSA administrator, if you have questions concerning eligible expenses.

Welcome To Health Choice

How Health Choice Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

■ The Flexible Spending Accounts

How The Flexible Spending Accounts Work

Your Dependents

Eligible Expenses

Flexible Spending Account Worksheets

Your Best Tax Advantage

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Dependent Care Spending Account Worksheet

Your Eligible Child Care Expenses (maximum annual contribution: \$5,000*)	Estimated Costs
Expenses that allow you and your spouse to work or attend school full time, including:	\$
Payments to licensed dependent care centers (for children or adults), nursery schools, after-school programs and day camps that meet state and/or local regulations, provide care for more than six nonresident people and receive fees for services provided	\$
Wages or salary paid to an individual (other than a family member) for care provided in or outside your home	\$
Expenses for household services (such as preparing meals) related to the care of an eligible dependent	\$
Social Security (FICA) and other taxes you pay on behalf of a care/service provider	\$
Your Total Estimated Health Care Expenses	\$

Please call Human Resources if you have questions concerning eligible expenses.

**The following special limits apply if you are married:*

If this is your situation ...	Then your maximum annual contribution is:
You or your spouse earn less than \$5,000	The amount the lower-paid spouse earns
Your spouse also participates in a similar dependent care account	\$5,000 combined
You file separate federal income tax returns	\$2,500
Your spouse is a full-time student for at least 5 months of the year or is disabled	\$2,500 if you have one dependent; \$5,000 if you have 2 or more dependents

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

■ The Flexible Spending Accounts

How The Flexible Spending Accounts Work

Your Dependents

Eligible Expenses

Flexible Spending Account Worksheets

Your Best Tax Advantage

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Your Best Tax Advantage

Under current tax law, you can pay for eligible dependent care expenses with before-tax dollars through the Dependent Care Spending Account, or you can claim a tax credit for dependent care costs when you file your federal tax return. You may use both approaches, but you can't "double deduct" for the same expense.

In addition, the amount of expenses that will qualify for a tax credit will be reduced dollar for dollar — by any amount you receive from the Dependent Care Spending Account.

This means:

- If you have one dependent, total expenses eligible for the tax credit are \$3,000 (or your actual expenses, if less) minus any amount received through the Dependent Care Spending Account. If you contribute the maximum \$2,500 to the Dependent Care Spending Account, this would leave \$500 eligible for the tax credit.
- If you have two or more dependents, total expenses eligible for the tax credit are \$6,000 (or your actual expenses, if less) minus any amount received through the Dependent Care Spending Account. If you contribute the maximum \$5,000 to the Dependent Care Spending Account, this would leave \$1,000 eligible for the tax credit.

For specific advice about your situation, you should contact a tax specialist.



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

■ **Voluntary Benefits**

Retirement Programs

Other Resources

Completing Your Online Enrollment

Contacts

Voluntary Benefits

You also have the option of enrolling in additional benefits. These benefits are offered at competitive group rates, which could save you money compared with purchasing them on your own. The Hospital for Special Surgery is making these benefits available to its employees, but is not sponsoring or endorsing them. These benefits are not subject to ERISA. If you have any questions about these benefits, contact Mercer at 855-244-6028.

<p>Critical Illness Insurance (MetLife)</p>	<p>If you are diagnosed with a critical illness, you will need financial protection to help cover the costs of your medical expenses, treatments and other out-of-pocket expenses — so that you can focus on getting better, rather than on your financial situation or your family’s future. In the event you are diagnosed with a covered illness, you will receive a cash benefit that you can use however you like.</p> <ul style="list-style-type: none"> ■ Covered illnesses include cancer, heart attack, stroke, coronary artery bypass graft, kidney failure, Alzheimer’s disease or a number of other conditions ■ Your spouse and children are also eligible for coverage under the plan ■ You are guaranteed coverage, without having to submit a Statement of Health (also known as Evidence of Insurability, or EOI) or answer health questions ■ The premiums can be conveniently deducted from your paycheck after-tax ■ When you file a claim, the cash benefit will be paid to you, for you to use however you wish
<p>Allstate Identity Protection Pro Plus (Formerly known as InfoArmor)</p>	<p>Services from Allstate that monitor your identity, detect fraud and restore your identity in the event of theft:</p> <ul style="list-style-type: none"> ■ Get peace of mind by protecting yourself against the damage of identity theft ■ Certified privacy advocates act on your behalf to resolve identity theft issues ■ The premiums can be conveniently deducted from your paycheck after-tax
<p>Legal Benefits (MetLife/Hyatt Legal)</p>	<p>The MetLife® Hyatt Legal Assistance Plan offers economical access to attorneys for legal services such as will preparation, estate planning and family law:</p> <ul style="list-style-type: none"> ■ Give yourself, your spouse and your dependents access to a nationwide network of 15,000 attorneys ■ Legal advice is a phone call away, and representatives will help you find an attorney in your area ■ This benefit is paid for by post-tax payroll deductions
<p>Pet Insurance (Nationwide)</p>	<p>Nationwide provides coverage to help you cover the costs of veterinary care:</p> <ul style="list-style-type: none"> ■ Protect against the financial impact of veterinary care while using any veterinarian worldwide ■ You are eligible to receive exclusive employee rates ■ You will be billed directly for these services; costs are not taken by payroll deduction ■ Enroll online at www.petsnationwide.com

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

■ Retirement Programs

Retirement Plan (Cash Balance Plan)

403(b) Plan

Other Resources

Completing Your Online Enrollment

Contacts

Retirement Programs

An investment in your future: As part of our commitment to providing plans that help employees save for the future, HSS offers the following retirement plans:

- **HSS Retirement Plan (Cash Balance Plan):** A 100% HSS-paid retirement plan that grows throughout your career to help you save for retirement (available to employees hired before October 17, 2009).
- **HSS 403(b) Plan, includes the Retirement Savings Plan Component:** Based on eligibility HSS will make an employer contribution (for employees hired on or after October 17, 2009) as well as allow all employees to make voluntary contributions into this retirement plan to help you supplement your retirement savings.

HSS Retirement Plan (Cash Balance Plan)

Available to employees hired prior to October 17, 2009.

Through the HSS Cash Balance Plan, each year that you are an active participant, the Hospital will credit an amount to your account that is equal to a percentage of your eligible base pay for the year. The percentage, referred to as a contribution credit, will be applied as of December 31 of each year. The percentage is based on your date of hire and years of service. In addition to the annual compensation credit, your Cash Balance Plan will earn a yearly interest 4.5%.

Benefits at a Glance

Below are some key features of the Plan:

- If you were employed with HSS on October 16, 2009, and you elected pursuant to the 2009 Retirement Choice Program to remain a Participant, your participation in the Plan continued. If eligible, participation under the Plan begins on the January 1 or July 1 coincident with or next following the completion of two (2) Anniversary Years in which you worked at least 1,000 hours.
- If you were employed with HSS on October 16, 2009, and you elected pursuant to the 2009 Retirement Choice Program to become a Retirement Savings Plan participant, your active participation in the Plan ceased, effective December 31, 2009. Your Cash Balance Account will remain in the Plan until your retirement or termination of employment. Your Normal Retirement Benefit was determined as of December 31, 2009 and remains frozen at that level until your benefit begins.
- **If you were first hired on or after October 17, 2009, you are not eligible to participate in the Plan.**
- You are fully vested in your benefit under the Plan once you become a participant.
- Once you become a Participant, you earn benefits back to your original date of hire as long as you worked at least 501 hours in the Plan Year you were hired.
- Your benefit under the Plan is expressed in the form of a Cash Balance Account which grows with Compensation and Interest Credits.
- Your benefits accumulate annually on a tax-deferred basis until you receive a distribution from the Plan.
- You are eligible to receive benefits from the Plan when you retire or leave HSS and can choose to receive payment either as a lump sum (a one-time payment) or in one of several different types of annuities (an annuity is a monthly payment).
- HSS pays the full cost of the Plan and Plan assets are held in a dedicated Trust for which HSS assumes all investment risk.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Retirement Plan (Cash Balance Plan)

403(b) Plan

Other Resources

Completing Your Online Enrollment

Contacts

Who Is Eligible to Participate

You are an eligible Employee if you are employed by HSS with a hire date prior to October 17, 2009, you elected to participate in the Plan pursuant to the 2009 Retirement Choice Program and you are not in one of the following categories:

- An Employee covered by a collective bargaining agreement that does not specifically provide for Plan participation;
- A “leased employee” within the meaning of the Code;
- An independent contractor;
- A nonresident alien;
- An Employee who has a medical staff appointment;
- An Employee classified as a member of the senior management staff; or
- An Employee who is a department head.

Credit Service	Annual Pay Credit
0 year, but less than 5 years	5%
5 year, but less than 10 years	6%
10 years, but less than 15 years	7%
15 years, but less than 20 years	8%
20 years or more	10%

As an employee, you are eligible to participate in the Cash Balance Plan and are automatically enrolled on the first of the month following your date of hire.

You become vested in the Cash Balance Plan after you have completed three years of service and must work 1,000 hours annually.

The following example illustrates how your Cash Balance will grow.

Mary was hired on January 1, 2005 in a full-time position (i.e., she is expected to work over 1,000 Hours of Service annually). Her starting salary was \$40,000 and her date of birth is January 1, 1970. Mary elected to continue participation in the Plan under the 2009 Retirement Choice Program.

Mary’s Cash Balance Account accumulates as follows:

Year	Age at January 1	Years of Service at January 1	Cash Balance Account at January 1	Salary	Compensation Credit Percentage	Compensation Credit	Interest Credit
2005	35	0	\$0	\$40,000	5.0%	\$2,000	\$0
2006	36	1	\$2,000	\$42,000	5.0%	\$2,100	\$ 90
2007	37	2	\$4,190	\$44,000	5.0%	\$2,200	\$189
2008	38	3	\$6,579	\$46,000	5.0%	\$2,300	\$296
2009	39	4	\$9,175	\$48,000	5.0%	\$2,400	\$413
2010	40	5	\$11,988	\$50,000	6.0%	\$3,000	\$ 539
2029	59	24	\$170,697	\$88,000	10.0%	\$8,800	\$7,681
2030	60	25	\$187,178	\$90,000	11.5%	\$10,350	\$8,423
2031	61	26	\$205,951	\$92,000	11.5%	\$10,580	\$ 9,268
2032	62	27	\$225,799	\$94,000	11.5%	\$10,810	\$10,161
2033	63	28	\$246,770	\$96,000	11.5%	\$11,040	\$11,105
2034	64	29	\$268,915	\$98,000	11.5%	\$11,270	\$12,101
2035	65	30	\$292,286				

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

■ Retirement Programs

Retirement Plan (Cash Balance Plan)

403(b) Plan

Other Resources

Completing Your Online Enrollment

Contacts

HSS 403(b) Plan, includes the Retirement Savings Plan Component

The Plan consists of two components: the 403(b) Plan or elective deferral component (available to all employees), and the Retirement Savings Plan or employer contribution component which applies only for certain eligible Employees hired on or after October 17, 2009. The 403(b) Plan component allows you to elect to defer a portion of your salary into your Account.

The Retirement Savings Plan component provides contributions by HSS to the Accounts of certain eligible Employees. The Plan is intended to provide you with an additional source of retirement savings for your retirement years. When combined with Social Security, any other retirement benefits you may receive from plans sponsored by HSS, and your personal savings for retirement, the Plan can help you enjoy a financially secure future.

Benefits at a Glance

Below are some key features of the Plan for eligible Employees in New York¹.

- If you are an Employee of HSS, other than a “leased employee,” you can contribute up to \$19,500 in 2019 or up to 80% of your Compensation to the Plan (if less)
- Your contributions are made before payroll taxes are deducted (on a pre-tax basis)
- You may contribute to a Roth IRA and make contributions after tax
- If you were hired prior to October 16, 2009 and elected as part of the 2009 Retirement Choice Program to receive employer contributions under the Retirement Savings Plan component, you began participating in the Retirement Savings Plan component as of January 1, 2010
- If you are eligible to receive employer contributions under the Retirement Savings Plan component, and were hired October 16, 2009 or later, you will begin participating in the Retirement Savings Plan component beginning the first of the month following your completion of one year of eligibility service
- Once you begin participating in the Retirement Savings Plan component, HSS will make contributions to an Account established for you with Transamerica Retirement Solutions (“TRS”), the Plan Recordkeeper, ranging from 4.0% to 8.0% of your Compensation each pay period
- You have the responsibility to direct how your contributions and HSS contributions are invested from a choice of Investment Options selected by HSS and available through TRS
- The contributions (both your contributions and HSS contributions) and earnings thereon accumulate tax-deferred until you receive them from the Plan
- You are eligible to receive benefits from the Plan when you retire or leave HSS; you may also be eligible for in-service withdrawals and loans with respect to certain contributions
- After termination, you can choose to receive payment either as a lump sum (a one-time payment), installments (a series of substantially equal payments), or as one of several different types of annuities (an annuity is a monthly payment), subject to the rules of the Funding Agent

¹ If your primary place of employment is Florida, the amount of your contributions is different, and is described in a separate SPD. Please refer to the SPD that applies to you.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

■ **Retirement Programs**

Retirement Plan (Cash Balance Plan)

403(b) Plan

Other Resources

Completing Your Online Enrollment

Contacts

Voluntary 403(b)

Who Is Eligible To Participate

You are eligible to participate in the Plan and make elective deferral contributions to your Account if you are an Employee of HSS, other than;

- An independent contractor; or
- A leased employee;

Individuals classified by HSS as independent contractors and individuals not classified as Employees because they are treated as providing services to another entity providing service to HSS, are not eligible to participate in the Plan during the period of such classification, even if such individuals are later retroactively classified by a court or administrative agency as common law employees.

When Does Participation Begin

Your participation in the Plan for purposes of making 403(b) Plan elective deferral contributions begins as soon as reasonably practicable after you complete and submit your salary reduction agreement to the Plan Recordkeeper.

For Retirement Savings Plan contributions, if you were hired prior to October 16, 2009 and you chose to receive Retirement Savings Plan contributions rather than to participate in The Hospital for Special Surgery Retirement Plan, you automatically became eligible to participate and began being credited with HSS contributions effective on the first pay period in January 2010.

Employees hired on or after October 16, 2009 who are eligible to receive Retirement Savings Plan contributions will begin being credited with HSS contributions on the first of the month following the completion of one year of eligibility service. You will earn a year of eligibility service if you work 1,000 hours or more in the 12 months following your date of hire or in any Plan Year thereafter.

How You Can Stop and Resume Your Elective Deferrals

You can stop contributing elective deferrals to the Plan at any time. You can resume contributions to the Plan at any time as permitted by the Plan.

Employer Contributions under the Retirement Savings Plan component – For employees hired on or after October 17, 2009

Who is Eligible to Participate

You must meet additional requirements to receive Retirement Savings Plan contributions. If you meet the above rule (you are an Employee who is not an independent contractor or a leased employee), you are eligible to receive Retirement Savings Plan contributions unless you are:

- An Employee covered by a collective bargaining agreement that does not specifically provide for Retirement Savings Plan contributions;
- An Employee who is a Medical Staff Appointment;
- An Employee who is a Research Scientist Staff Appointment;
- An Employee who is an Assistant Vice President or equivalent or higher level management position, a General Counsel office attorney or a Controller;
- Participating in The Hospital for Special Surgery Retirement Plan; or
- A nonresident alien.

Years of Benefit Service	Employer Contribution (as a percentage of Compensation)
Less than 1	0%
1 but less than 5	4%
5 but less than 10	5%
10 but less than 15	6%
15 but less than 20	7%
20 or more	8%

Vesting

Vesting is your right to the value of funds in your Plan Account. You are always 100% vested in the value of your account.

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

■ Other Resources

Health Advocate

ReThink

Employee Assistance Program

Completing Your Online Enrollment

Contacts

Other Resources

Health Advocate

Health Advocate is the nation's leading healthcare advocacy and assistance company. Their experts make healthcare easier, by helping employees and their eligible family members navigate the healthcare system, resolve healthcare and insurance issues, and get the right care at the right time.

Personal Health Advocates are typically registered nurses, supported by medical directors and benefits and claims specialist. Health Advocate's services are provided to employees and their eligible family members at no cost. Employees, their spouse, dependent children, parents and parents-in-law can all access Health Advocate's services as often as they like.

Issues Health Advocate can help you with:

Help with Medical Care

- Learn more about your diagnosis and treatment
- Get answers to your questions about medical conditions
- Find out the latest research and most advanced approaches to care
- Connect with the right in-network doctors and specialists, obtain second opinions
- Clarify Medicare, Medicare Supplement plans and Medicaid

Help with Administrative Issues

- Get answers to benefits, eligibility and coverage questions
- Navigate through copays, coinsurance and cost-sharing
- Get assistance transferring medical records
- Untangle medical bills and resolve claims and billing issues

Help On the Go

- Download the app to access all of your Health Advocate benefits
- Get informed with health and wellness articles and more
- View personalized advice based on your health needs and goals
- Check the status of your Health Advocate cases, upload documents
- View your case history to access the information you need

Health Advocate provides 24/7 support.

Call: 866.695.8622

Email: Answers@HealthAdvocate.com

Web: [HealthAdvocate.com/members](https://www.healthadvocate.com/members)

Additional information is available on the Benefits Administration website — www.hss.bswift.com — in the Library section, and on the HR Intranet page, Health and Welfare section (on the Intranet page click on the following to access the HR Intranet page – Departments and Committees, Human Resources).

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

■ **Other Resources**

Health Advocate

ReThink

Employee Assistance Program

Completing Your Online Enrollment

Contacts

ReThink

ReThink's award-winning, research-based program provides support to parents raising children with learning or behavior challenges, or developmental disabilities. Parents receive free, live tele-consultations with behavioral health experts to answer questions, and provide guidance and resources.

Common tele-consultation topics include:

- Teaching new skills
- Addressing problem behaviors at home
- Troubleshooting lack of progress
- Collaborating with school and other providers

Additionally, ReThink provides parents with hundreds of easy-to-follow videos depicting behavioral health experts teaching children skills such as language, socialization, self-help, academics, vocational, and more. Printable materials as well as on-demand web-based training complement these tools as parents support their children in reaching their top potential.

To access ReThink, visit <http://HSS.rethinkbenefits.com> (Enrollment Code: HSS).



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

■ Other Resources

Health Advocate

ReThink

Employee Assistance Program

Completing Your Online Enrollment

Contacts

Employee Assistance Program Consortium (EAPC)

EAPC offers free, professional and totally confidential in person and telemental health counseling. You can also get referrals for a broad range of issues.

The EAPC is staffed by license by clinical social workers and consulting psychiatrists. They offer individual, couples and family counseling, and referrals for longer-term and specialized treatment and community-based services.

EAPC's services are provided to employees at no cost.

Issues EAPC can help with:

The EPAC staff can assist you with both everyday problems and crisis situations.

They can help you understand and address:

- Work and school challenges
- Relationship and family problems
- Stress and anger management
- Grief and loss
- Domestic Violence
- Alcoholism and substance abuse
- Parenting concerns
- Eating disorders and body image issues
- Coping with illness and health concerns
- Legal and financial referrals
- Personal growth and well-being
- Coping with traumatic events

EAPC is available Monday – Friday 9am – 5pm.

On call service for urgent after hour matters is also available.

Call: 212.746.5890

Email: EAPC@med.cornell.edu

Web: www.youreapc.us

Additional information is available on the Benefits Administration website – www.hss.bswift.com – in the Library section, and on the HR Intranet page, Health and Welfare section (on the Intranet page click on the following to access the HR Intranet page - Departments and Committees, Human Resources).

Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

■ **Completing Your Online Enrollment**

Contacts

Completing Your Online Enrollment

Instructions for completing your enrollment are available on the Benefits Administration site — <http://www.hss.bswift.com> — in the News & Library section on the Welcome Page.



Any Questions?

If you have questions, or simply need more information about Health Choice, contact the HSS Benefits Team at: HRBenefits@hss.edu

■ **Tiffany Iannizzotto**
Senior Benefits Analyst
646-797-8483

■ **Narica Persaud**
Benefits Financial
Audit Analyst
646-797-8204

■ **Carla Rivera**
Sr. Benefits Analyst
646-797-8972

■ **Carlita Sosa**
Senior Director, Benefits Administration
212-774-7650

■ **Lilliana Torres**
Manager, Benefits
212-774-2708



Welcome To *Health Choice*

How *Health Choice* Works

The Medical Plan

Prescription Drug Coverage

The Dental Plan

The Vision Plan

The Long-Term Disability Plan

The Life Insurance Plan

The Accidental Death & Dismemberment Plan

The Health Savings Account

The Flexible Spending Accounts

Voluntary Benefits

Retirement Programs

Other Resources

Completing Your Online Enrollment

■ **Contacts**

Contacts

Benefit	Provider	Phone	Website
Medical ■ Group Number: 0715617	United Health Care ■ High Plan ■ Low Plan ■ EPO Plan ■ Premium Plan ■ CDHP	800-741-8786 888-761-0337	www.myuhc.com
Prescription Drugs ■ Group Number: PV2497001O9701 If enrolled in the CDHP, your Rx group number is UHCHSA001O9701	Express Scripts	800-818-0093	www.express-scripts.com
Dental ■ Group Number: 230555	MetLife	800-942-0854	metlife.com/mybenefits
Vision ■ Group Number: 344291	Guardian	800-541-7846	www.guardiananytime.com
Health Savings Account (HSA) ■ Group Number: 715617	Optum	800-791-9361	www.optumbank.com
Flexible Spending Accounts (FSAs)	UltraBenefits	866-858-7223	www.ultrabenefits.com
Life Insurance/AD&D/ Long-Term Disability (LTD) ■ Group Number: 675690	The Hartford	888-563-1124	www.thehartford.com
Health Advocacy – Expert healthcare and insurance help	Health Advocate	866-695-8622	www.healthadvocate.com/members
Commuter Benefits	TransitCenter	888-618-2435	www.transitchek.com
Retirement Plan	Transamerica	800-755-5801	hss.trretire.com
Voluntary Supplemental Insurance	AFLAC	718-423-6000 ext.208	www.aflac.com/hss
Critical Illness	MetLife	800-438-6388	www.metlife.com/MyBenefits*
Identity Protection	Allstate Identity Protection Pro Plus (InfoArmor)	800-789-2720	www.myprivacyarmor.com
Legal Services	MetLife Hyatt	800-821-6400	www.info.legalplans.com (access code: 9900271)
Pet Insurance	Nationwide	877-738-7874	www.petsnationwide.com
Voluntary Supplemental Insurance	First UNUM	800-375-8226	www.unumprovident.com
Employee Assistance Program	The Employee Assistance Program Consortium (EAPC)	212-746-5890	www.youreapc.us
Credit Union	Municipal Credit Union	212-693-4900	www.nymcu.org
Tobacco Cessation Program	Quit For Life	866-784-8454	www.quitnow.net

* This website will only be available to participants who have enrolled in the Critical Illness plan. Participants will be able to access plan information, certificates, claim forms, etc., related to the Critical Illness plan.

Welcome To The Health Choice

The Medical Plan
Prescription Drug Coverage The
Dental Plan
The Vision Plan
The Long-Term Disability Plan
The Life Insurance Plan
The Accidental Death &
Dismemberment Plan
The Health Savings Account
The Flexible Spending Accounts
Voluntary Benefits Retirement
Programs
Other Resources
Completing Your Online
Enrollment

■ Contacts

ANNUAL ERISA NOTICES – HOSPITAL FOR SPECIAL SURGERY HEALTH PLAN NOTICES

For Plan Year January 1, 2021 Women’s Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns’ and Mothers’ Health Protection Act Notice

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

issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

CHIP/MEDICAID NOTICE

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)**.

Welcome To The Health Choice
 How Health Choice Works
 The Medical Plan
 Prescription Drug Coverage The
 Dental Plan
 The Vision Plan
 The Long-Term Disability Plan
 The Life Insurance Plan
 The Accidental Death &
 Dismemberment Plan
 The Health Savings Account
 The Flexible Spending Accounts
 Voluntary Benefits Retirement
 Programs
 Other Resources
 Completing Your Online
 Enrollment

■ **Contacts**

State	Provider	Phone/Email	Website
ALASKA The AK Health Insurance Premium Payment Program	Medicaid	1-866-251-4861 CustomerService@MyAKHIPP.com	myakhipp.com Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS	Medicaid	1-855-MyARHIPP (855-692-7447)	myarhipp.com
CALIFORNIA	Medicaid	916-440-5676	dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
COLORADO (Colorado's Medicaid Program) & Child Health Plan Plus		1-800-221-3943/ State Relay 711	healthfirstcolorado.com
	(CHP+)	Customer Service: 1-800-359-1991/ State Relay 711	colorado.gov/pacific/hcpf/child-health-plan-plus-CHP+
	Health Insurance Buy-In Program (HIBI)	HIBI Customer Service: 1-855-692-6442	https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
FLORIDA	Medicaid	1-877-357-3268	flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html
GEORGIA	Medicaid	678-564-1162 ext 2131	medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
IOWA			
INDIANA Plan for low-income adults 19-64	Medicaid	1-877-438-4479	in.gov/fssa/hip
All other Medicaid		1-800-457-4584	in.gov/medicaid
KANSAS	Medicaid	1-800-792-4884	kdheks.gov/hcf/default.htm

Welcome To The Health Choice
 How Health Choice Works
 The Medical Plan
 Prescription Drug Coverage The
 Dental Plan
 The Vision Plan
 The Long-Term Disability Plan
 The Life Insurance Plan
 The Accidental Death &
 Dismemberment Plan
 The Health Savings Account
 The Flexible Spending Accounts
 Voluntary Benefits Retirement
 Programs
 Other Resources
 Completing Your Online
 Enrollment

■ **Contacts**

State	Provider	Phone/Email	Website
KENTUCKY	Medicaid	KI-HIPP: 1-855-459-6328 KCHIP: 1-877-524-4718	<ul style="list-style-type: none"> • Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) • Kids Health • Kentucky Medicaid
LOUISIANA	Medicaid	1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	medicaid.la.gov or www.ldh.la.gov/lahipp
MAINE Private Health Insurance Premium:	Medicaid	Enrollment: 1-800-442-6003	maine.go/dhhs/ofi/applications-forms
		1-800-977-6740 TTY: Maine relay 711	maine.go/dhhs/ofi/applications-forms
MASSACHUSETTS	Medicaid and CHIP	1-800-862-4840	mass.go/eohhs/go/departments/masshealth
MINNESOTA	Medicaid	1-800-657-3739	mn.go/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
MISSOURI	Medicaid	573-751-2005	dss.mo.go/mhd/participants/pages/hipp.htm
MONTANA	Medicaid	1-800-694-3084	dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
NEBRASKA			
NEVADA	Medicaid	1-800-992-0900	dhcftp.nv.gov
NEW HAMPSHIRE	Medicaid	603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	dhhs.nh.go/oi/hipp.htm
NEW JERSEY	Medicaid	609-631-2392	state.nj.us/humanservices/dmahs/clients/medicaid
	CHIP	1-800-701-0710	njfamilycare.org/index.html
NEW YORK	Medicaid	1-800-541-2831	health.ny.go/health_care/medicaid
NORTH CAROLINA	Medicaid	919-855-4100	medicaid.ncdhhs.go

Welcome To The Health Choice
 How Health Choice Works
 The Medical Plan
 Prescription Drug Coverage
 The Dental Plan
 The Vision Plan
 The Long-Term Disability Plan
 The Life Insurance Plan
 The Accidental Death &
 Dismemberment Plan
 The Health Savings Account
 The Flexible Spending Accounts
 Voluntary Benefits
 Retirement Programs
 Other Resources
 Completing Your Online
 Enrollment

■ **Contacts**

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

Welcome To The Health Choice
How Health Choice Works
The Medical Plan
Prescription Drug Coverage
The Dental Plan
The Vision Plan
The Long-Term Disability Plan
The Life Insurance Plan
The Accidental Death &
Dismemberment Plan
The Health Savings Account
The Flexible Spending Accounts
Voluntary Benefits
Retirement Programs
Other Resources
Completing Your Online
Enrollment

■ **Contacts**

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

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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.