Benefit Enrollment Guide 2024

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A Message from HR at Wilson Health

At Wilson Health we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Thank you for all that you do for each other and for Wilson Health. We could not do it without you.

Sincerely,

Sarah Burmeister
Human Resources

Eligibility

Eligibility

Most employees are eligible for the benefits described in this guide. You are eligible for some, but not all benefits if you work at least 20 hours per week. New hire benefits are effective on the first day of the month following 30 days of employment.

Eligible Dependents

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your legally married spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship. *Spouses who have access to their employer-provided health plan are not eligible to be covered under the Wilson Health health plan. However, any spouse that does not have access to their employer-provided health plan, or does not work outside the home, continues to be eligible.* Same sex legal marriages will follow the same eligibility rules listed above. All dependent children up to age 26 are eligible for coverage. Formal guardianship or custodial documents may be requested.

When Coverage Begins

The effective date for your benefits is January 1, 2024. Newly hired employees and dependents will be effective in Wilson Health's benefits programs. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status event.

Family Status Change

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact Human Resources to make these changes.

Open Enrollment Instructions

Paycor is our online enrollment tool. The site is accessible via the Wilson Health Intranet by clicking the Paycor Link and can be accessed 24 hours a day, seven days a week. This year, **Wilson Health's enrollment is ACTIVE— therefore, all current elections will need to be selected during open enrollment or the benefits will be forfeited until January 1st, 2025. To make changes, please log into Paycor.**

BEFORE YOU ENROLL

Review Your Options & Make Your Choices

Take time to review the information in the Plans section. It will help you understand your benefit choices. Discuss it with your family too!

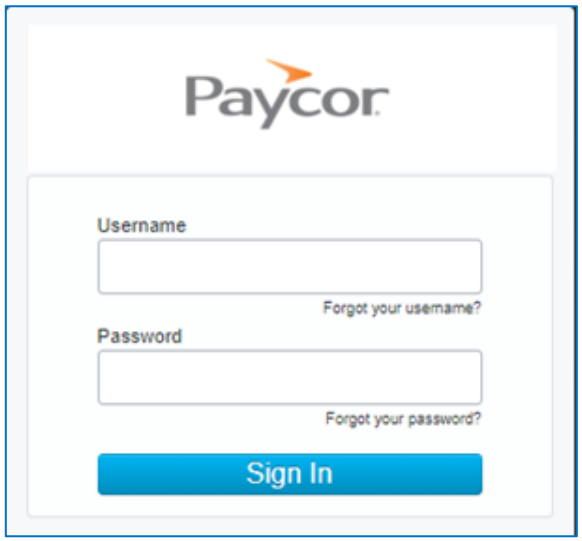
STEPS TO COMPLETE YOUR ENROLLMENT

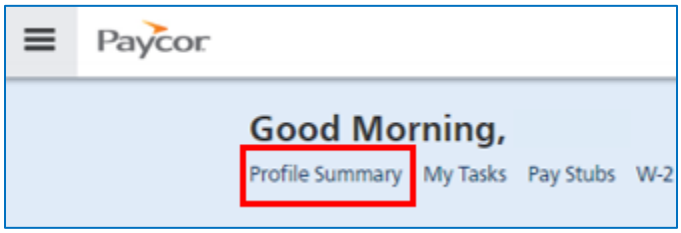
Download on the App Store

GET IT ON Google Play

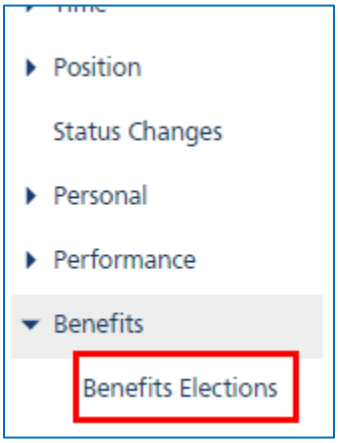
SCAN ME

Step 1: Login to Paycor or scan the QR code to get started!
Once signed into Paycor, click profile summary





STEP 2: Click Benefits, then Benefit Elections



STEP 3: Select **Start Your Enrollment** on the message board to get started!

Medical Insurance

Medical Benefits

Wilson Health's medical plan designs will continue to offer two High Deducible Health Plans and a PPO Plan. UMR is the **NEW** claims administrator providing access to Wilson Health and UMR providers. In order for your PCP visit to be covered, you must see a Wilson Health PCP. If you do not utilize a Wilson Health PCP, then it would be considered out-of-network and there will be no coverage for that visit. In-Network Benefits are referenced in the chart below. Please refer to the Summary of Benefits and Coverage to review Out-of-Network benefits.

Plan Provisions	Basic HDHP/HSA		Premium HDHP/HSA		PPO Plan	
	Wilson Hospital/Wilson Medical Group	UHC In-Network Providers	Wilson Hospital/Wilson Medical Group	UHC In-Network Providers	Wilson Hospital/Wilson Medical Group	UHC In-Network Providers
Annual Deductible (Single/Family)	$2,500/$5,000 Aggregate	$4,000/$8,000 Aggregate	$2,000/$4,000 Aggregate	$3,000/$6,000 Aggregate	$1,500/$3,000 Embedded	$3,000/$6,000 Embedded
Coinsurance	100%	75%	100%	75%	80%	70%
Out-of-Pocket Maximum	$2,500/$5,000	$7,000/$14,000	$2,000/$4,000	$6,000/$12,000	$4,000/$8,000	$8,000/$16,000
PCP/Specialist	100% after deductible	Not covered / 75% after deductible	100% after deductible	Not covered / 75% after deductible	$25 / $50 copay	Not covered / $75 copay
Emergency Services	100% after deductible		100% after deductible		$250 copay	$400 copay
Hospital Services Inpatient/Outpatient	100% after deductible	75% after deductible	100% after deductible	75% after deductible	80% after deductible	70% after deductible
Wellness/Preventive /Routine Care	100%; no ded.	100%; no ded.	100%; no ded.	100%; no ded.	100%; no ded.	100%; no ded.

The examples shown below references the PPO Plan and the Wilson Health Basic HDHP/HSA:

Embedded Deductible = Each covered family member has an individual deductible of $1,500 with a family maximum of $3,000. When an individual meets $1,500, then the medical plan will pay 80% of covered charges.

Aggregate (non-embedded) Deductible = For coverage other than employee only, the family deductible of $5,000 must be met before the medical plan begins paying 100% of covered charges. All family members' eligible out of pocket expenses count toward the family deductible until it has been met.

Pharmacy Drug Copays

Wilson Health Pharmacy Benefits	For Basics and Premium HDHP Plans After Integrated Med/Rx Deductible
Preventive Generic	100%, no Deductible
Generic	100%, no Deductible
Brand Name Drug	100%, no Deductible
Specialty Drugs	100%, no Deductible
Injectable Drugs	Must be purchased at Wilson Health

Other Retail Pharmacy Benefits	For Basics and Premium HDHP Plans After Integrated Med/Rx Deductible	For PPO Plan After Integrated Med/Rx Deductible
Preventive Generic	100%, no Deductible	100%, no Deductible
Tier 1 – Generic Drug	90% after Deductible	$10 copay (34 day & 90-day supply)
Tier 2 – Preferred Brand	80%, no Deductible	$35 copay (34 day & 90-day supply)
Tier 3 – Non-Preferred Brand	60%, no Deductible	$60 copay (34 day & 90-day supply)
Specialty Drugs **Tier 1- Generic** **Tier 2 - Preferred** **Tier 3 – Non-Preferred**	 90%, no Deductible 80%, no Deductible 60%, no Deductible	$60 copay Note: Injectable drugs must be purchased through Wilson Health Pharmacy for PPO Plan

Note:
Coordination of benefits for prescription drugs will be administered.
Please reference your 'Summary of Benefits and Coverage' (SBC) for full detail on the embedded versus aggregate under the deductible and out-of-pocket maximum. Preventive/Routine care include adult physical exam, mammography, gynecological, pap smear, prostate, colorectal, and colonoscopy. Well Child Care includes exams for sports, eligible exams are office visit only, see plan documents for full details.

This is a summary of your coverage only. Please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges. Subject to plan document coverage and exclusions. Includes all eligible physician and facility charges.

TRUESCRIPTS—your Pharmacy Benefit Manager!

Note: Once you receive your Member ID card, please be sure to enroll online!

Drug Price Lookup

Drug prices can vary significantly from pharmacy to pharmacy. Our Drug Price Lookup tool allows you to quickly and easily check real-time pricing on your medications so that you always get the best price!

Pharmacy Locator

With more than 70,000 pharmacies in the TrueScripts network, you are sure to find one convenient to you. To search our database of pharmacies, just enter your preferred location into our Pharmacy Locator tool.

My Plan

Access your plan structure to identify individual and family out-of-pocket and deductible amounts, as well as co-pay amounts for various types of drugs.

My Claims

Track claims information, including co-pay totals, for you and your eligible dependents.

Additional resources, including money-saving tips and member forms, are located inside the TrueScripts Member Portal as well. This portal is intended to serve as an added layer of service for our members. Our team of clinical experts and care specialists are also available to provide assistance and ***Amazing Care!***

TrueScripts™ Amazing Care

We Are Experts in Prescription Benefits.
And we are here for **you!**
PartnerWithUs@TrueScripts.com

Medical Contributions

Employee Contributions (Bi-weekly)		
Basic HDHP Contributions	Full-time	Part-time (ACA Eligible Employee)
Employee	$40.72	$106.02
Employee & Spouse	$85.49	$222.58
Employee & Child(ren)	$77.35	$201.39
Family	$122.08	$317.87
Premium HDHP Contributions	Full-time	Part-time (ACA Eligible Employee)
Employee	$63.40	$153.06
Employee & Spouse	$132.68	$321.42
Employee & Child(ren)	$120.94	$290.79
Family	$174.91	$431.34
PPO Plan Contributions	Full-time	Part-time (ACA Eligible Employee)
Employee	$79.53	$198.38
Employee & Spouse	$166.98	$416.60
Employee & Child(ren)	$151.08	$376.92
Family	$242.38	$614.97

***Tobacco / Nicotine Surcharge**

Our mission is to promote a healthy workplace and encourage you to make good choices that enhance your health and well-being. In an effort to keep you healthy we are continuing a surcharge for employees who use tobacco in any form (cigarettes, cigars, chewing tobacco, e-cigarettes, etc.), and/or nicotine (through a vaping device). During open enrollment you will be asked about your tobacco usage, if you use tobacco you will be charged $65 per bi-weekly paycheck in addition to your applicable medical employee contribution. You may participate in a tobacco cessation program to obtain the non-tobacco rate. Participants in this program will receive the premium reduction upon certification of program completion.

WILSON HEALTH

NEAR SITE CLINICS

SERVICES:

FREE to All Benefit Eligible Employees & Dependents covered by WH Medical Plan

3 Convenient Clinic Locations

Primary Care Services:

- Sick Visits
- Health Maintenance
- Wellness Visits
- Chronic Care
- Minor Wounds & Lacerations

FREE full prescriptions formulary via pick-up or mail order program

FREE Point of Care Testing

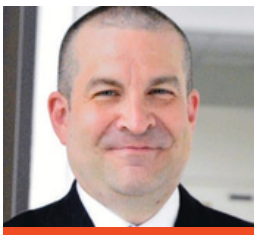
- Flu
- COVID-19
- Strep
- Urine
- Pregnancy

Discounted Lab Draws
Dietary Counseling
Occupational Health Services

EMPLOYER DIRECT CARE - SIDNEY

1079 Fairington Drive
Sidney, OH 45365
(937) 419-8057

Call or TEXT



Dr. Michael Beyer

CLINIC HOURS:

Monday	6:00 AM - 4:00 PM
Tuesday	8:00 AM - 2:00 PM
Wednesday	6:00 AM - 2:00 PM
Thursday	8:00 AM - 6:00 PM
Friday	6:00 AM - NOON

EMPLOYER DIRECT CARE - PIQUA

143 North Sunset (Suite 300)
Piqua, OH 45356
(937) 451-3220

Call or TEXT

Leslie Joseph, CNP

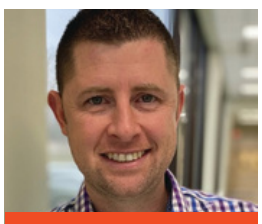
CLINIC HOURS:

Monday	8:00 AM - 6:00 PM
Tuesday	6:00 AM - 2:00 PM
Wednesday	8:00 AM - 4:00 PM
Thursday	6:00 AM - 2:00 PM
Friday	6:00 AM - NOON

COMMUNITY HEALTH CLINIC - ST. MARYS

315 Freewalt Way
St. Marys, OH 45885
(419) 400-2010

Call or TEXT



Lance Neely, CNP

CLINIC HOURS:

Tuesday	NOON - 4:00 PM
Thursday	NOON - 4:00 PM
Friday	8 a.m. - Noon

Wilson Health Wellness Program

$300 Possible Reward!

Whether your goal is to have more energy, lose weight, manage stress, or improve your diet, Wilson Health Wellness program can help you. We consider wellness to be a vital part of our overall benefits program.

As healthcare costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win — it means our employees are improving their lives, and we are one step closer to managing rising health insurance costs.

Visit Engage Intranet for more information about the Wilson Health Wellness Program.

✓ Complete Annual Physical with PCP/OBGYN

- $150 Reward

✓ Accumulate 5 Wellness Points

- $150 Reward

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

2024 HSA Contributions

You are able to contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

FOR THE 2024 TAX YEAR:

- Individual, $4,150
- Family, $8,300
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

What happens to the money in my HSA if I no longer have a HDHP?

Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through www.netbenefits.com 24 hours a day, seven days a week. Fidelity provides helpful information about your HSA, including online calculators to help you add up your tax savings and see your HSA's possible future growth. For additional guidelines, please go online or call Fidelity at 800-835-5097.

HSA Employer Seed Money

A Health Savings Account (HSA) empowers you to build savings for health expenses in a tax advantaged account. You can set up automatic payroll deductions, so your HSA contributions are withheld pre-tax. *Additionally, Wilson Health will contribute $500 annually into the account for those with single coverage and $1,000 annually for those with family coverage.*

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a program that helps you pay for health care and dependent care costs using tax free dollars. They work in a similar way to a health savings account. Each pay period, funds are deducted from your pay on a pre-tax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
General Purpose Health Care Flexible Spending Account	Most out-of-pocket medical, dental and vision expenses	Maximum contribution is $3,200 per year.	Saves on eligible expenses reduces your taxable income
Limited Purpose Health Care FSA (for those enrolled in an HSA-qualified medical plan)	Most out-of-pocket dental and vision care expenses that are not covered by your plan (such as copayments, coinsurance, deductibles, and eyeglasses)	Maximum contribution is $3,200 per year.	Saves on eligible expenses reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

IMPORTANT INFORMATION ABOUT FSAs

Your FSA elections are effective from January 1 through December 31. Claims for reimbursement must be submitted by March 15th of the following year for any claims incurred during the 2024 plan year. Please plan your contributions carefully. Any money remaining in your account after March 15th will be forfeited. This is known as the "use it or lose it" rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year. Keep receipts to verify eligible expenses.

ADVANTAGES OF AN FSA

With an FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year.

COORDINATING AN HSA WITH A LIMITED FSA

If you elect a Healthcare Flexible Spending Account (FSA), it will be a Limited FSA administered by Fidelity.

- You can receive reimbursement for dental and vision expenses.
- Remember, FSA funds do not roll over from year to year

SAVE ON YOUR TAXES

Here's a look at how much you can save when you use an HSA or FSA to pay for your health care and dependent care expenses.

Account Type	With HSA and/or FSA	Without HSA and/or FSA
Your taxable income	$50,000	$50,000
Pretax contribution to HSA, Limited Purpose Health Care FSA and/or Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$0	$2,000
After-tax dollars spent on eligible expenses	$36,299	$35,645
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with the HSA, Limited Purpose Health Care FSA and/or Dependent Care FSA	**$65**	**N/A**

* This is an example only and may not reflect your actual experience. It assumes a 25% Federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary and are not included in this example. However, you will also save on any state and local taxes.

GET INTO THE MEDICARE MINDSET

MEDICARE MINDSET

Medicare insurance coverage functions differently than other insurance coverage you've used throughout your life. We're here to simplify Medicare insurance planning so you stay well-informed and confident in your decisions.

WE PROVIDE

DETAILED COVERAGE ANALYSIS
We give you a personalized recommendation, whether that means delaying Medicare coverage or enrolling at the earliest eligibility.

EXPERT ADVICE
We clarify the various "parts" of Medicare (A, B, C, D, Medigap) and help you clearly see the difference between Original Medicare & Medicare Advantage.

ONGOING SUPPORT
We are here to help with all your Medicare needs, even as circumstances and plans change. We'll even help you get enrolled in Medicare.

WE PROMISE

- To provide the easiest transition to Medicare with a clear representation of the market and easy-to-follow insurance planning.
- To be fully transparent from start to finish and responsive to all emails and calls.
- To be with you every step of the way by keeping you inf updates and specific enrollment period dates.

For more information, please contact:

Andy Stamas
Medicare Mindset, LLC

Cell/Text: 937.620.3472 | **Office:** 866.656.4020 | **Fax:** 866.660.1484
andy@medicaremindset.com | medicaremindset.com

linkedin.com/company/medicaremindset

facebook.com/medicaremindset

youtube.com/c/medicaremindset

Dental Insurance

Dental Benefits

Wilson Health will continue to offer a dental program by Delta Dental of Ohio. If you choose to visit an out-of-network provider, you will pay higher cost for those services and may be balance billed. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Customer service at 800-524-0149 or visit www.deltaldentaloh.com

	Dental PPO
	In-Network Benefits
Annual Deductible	
Individual / Family	$50 / $150
Waived for Preventive Care?	Yes
Annual Maximum	
Per Person / Family	$1,500
Preventive	100%
Basic	80%
Major	50%
Orthodontia	
Benefit Percentage	60%
Dependent Child(ren)	Limited to eligible dependent children under age 19
Lifetime Maximum	$1,500

*Note – Special Health Care Needs Benefit is available for members with a qualified special health care need. Enhanced benefits include up to four total cleanings per year and additional dental visits and / or consultations. Also included are treatment delivery modifications necessary for dental staff to provide oral health care for patients with sensory sensitives, behavioral challenges, severe anxiety or other barriers to treatment.

Employee Contributions (Bi-weekly)		
Dental contributions	Full-time	Part-time (ACA Eligible Employee)
Employee	$7.49	$12.37
Employee & Spouse	$14.96	$24.69
Employee & Child(ren)	$18.64	$28.39
Family	$21.74	$39.14

ID Card Not Required

Delta Dental members receive top-notch services without a printed ID card. Simply tell your dentist that you're covered by Delta Dental, and the office staff will take it from there! However, if you would prefer to carry an ID card with you (either in electronic form or paper), get it one of these easy ways:

- Log in to Consumer Toolkit at www.consumertoolkit.com
- Call customer service at 800-524-0149,
- Download an electronic ID card through the Delta Dental mobile smartphone app for Apple and Android devices.

Vision Insurance

Vision Benefits

Wilson Health provides Vision Insurance through EyeMed Vision Care. The chart below is a brief outline of the plan. A reimbursement is available for out-of-network benefits.

Please refer to the summary plan description for complete plan details.

Customer Service:
866-939-3633
www.eyemed.com

	Vision Plan
	In-Network Benefits
Copay	
Routine Exams (Annual)	$20 copay
Vision Materials	
Materials	$0 copay
Lenses (Standard-Vision)	$20 copay; covered once every 12 months
Lenses (Progressive)	$50-$195 copay; covered once every 12 months
Contacts (Elective)	$0 copay; $180 allowance (Standard Fitting – Up to $40); coverd once every 12 months
Medically Necessary	$0 copay; paid-in-full
Frames	$0 copay; $200 allowance, 20% off remaining balance; covered once every 24 months

Employee Contributions (Bi-weekly)		
Vision contributions	Full-time	Part-time (ACA Eligible Employee)
Employee	$2.59	$3.46
Employee & Spouse	$4.49	$5.99
Employee & Child(ren)	$4.46	$5.95
Family	$7.19	$9.60

Life and AD&D

(Employer-Paid)

Wilson Health provides Basic Life and AD&D benefits to eligible employees through Lincoln Financial Group. You are only eligible for this benefit coverage if you are a full-time employee.

If your benefit amount is more than $50,000 annually, the money Wilson Health pays for your basic life insurance is taxable. This is called imputed income and is shown on your paystub as "GTL."

The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Important Reminder!
Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to you wishes.

Voluntary Term Life and AD&D

(Employee Paid)

Wilson Health also offers voluntary life and AD&D insurance through Lincoln Financial Group for additional family security. You may purchase this additional coverage for yourself, your spouse and/or your children. If you elect child coverage, one premium covers all eligible dependent children.

Disability Insurance

Disability Insurance can provide a sense of security knowing that if the unexpected should happen, you can still provide for yourself and your family.

Short-Term Disability Insurance

(Employer Paid)

Wilson Health provides a short-term disability option through Lincoln Financial Group to benefits eligble hourly employees. This benefit covers 60% of your weekly base salary up to $1,200. The benefit begins on the 1st day for Accident and on the 8th day for illness and lasts up to 13 weeks. Please see the summary plan description for complete plan details.

Long-Term Disability Insurance

(Employer Paid)

Wilson Health offers long-term income protection through Lincoln Financial Group in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of monthly disability earnings of your monthly base salary up to $6,000. Benefit payments begin after date of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

Coverage	Benefit
Short-Term Disability (STD) (Employer Paid) Hourly Employees Benefit Eligible	• Up to $1,200 per week • Covers up to 60% of your gross monthly salary • Benefits begin on the first day for accident and eighth day for illness and continue to the earlier of recover or 90 days
Long-Term Disability (LTD) (Employer paid if you are a full-time employee)	• Covers 60% of your monthly pre- disability earnings – up to a $6,000 monthly maximum • Benefit begins after 90 days of disability or illness and continue to the earlier of recovery or age 65 • Taxable benefit

Accident Insurance

(Employee Paid)

Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious like a broken nose. Your plan can pay benefits for emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage from your spouse and dependent children. This insurance coverage **includes a wellness benefit as shown in the chart below.**

Benefit Type	Benefit Amount
Health Assessment Benefit	$50 per Health Assessment Test
Child Health Assessment Benefit	$50 per Child Health Assessment Test
Individual Maximum of Tests	1 per person per Health Assessment Period

Critical Illness Insurance

(Employee Paid)

Critical Illness coverage can include serious conditions like a permanent paralysis, and some policies can provide coverage for cancer. Treatment for these conditions can be very expensive, so Critical Illness Insurance can help – by paying a lump sum directly to you at the first diagnosis of a covered condition. You decide how to spend the money, and you can also purchase coverage for your spouse. Dependent children are automatically covered at 50% of your benefit amount. This insurance coverage **includes a wellness benefit as shown in the chart below**.

Benefit Type	Benefit Amount
Health Assessment Benefit	$50 per Health Assessment Test
Child Health Assessment Benefit	$50 per Child Health Assessment Test
Individual Maximum of Tests	1 per person per Health Assessment Period
Overall Maximum of Test	6 per family, per Health Assessment Period
Overall Maximum Benefit Amount	$300 per family, per Health Assessment Period

WILSON HEALTH

Employee Assistance Program

What is EAP?

The Employee Assistance Program (EAP) is a service provided at no cost to employees of Wilson Health that provides confidential, outpatient counseling for those employees who seek solutions to better their lives. The first six visits for approved services, including a professional assessment and counseling, are paid for by Wilson Health for Active Casual/Part-Time/Full-Time Wilson Health employees and their families. Each employee and immediate family members are eligible for the services regardless of whether they are covered by Wilson Health's Medical Plan.

Services provided after the first six visits may be covered under your employer's sponsored plan.

The EAP services are offered by skilled professionals who have a wide range of experience working with personal and family concerns.

What services are included?

- Individual counseling
- Family counseling
- Alcohol and drug addiction counseling
- Support groups
- 24-hour crisis hotline

What types of problems does the EAP address?

Employees may need help with any number of problems. Some concerns may include marriage, parenting, grief, personal or work-place relationships, legal or financial issues, and drug or alcohol abuse.

When are services available?

Appointments are usually held during normal business hours, Monday through Friday. Appointments may be scheduled around work for your convenience. EAP services are also available 24-hours-a-day for crisis situations.

Where can I get more information?

To make a confidential appointment with a counselor, select a provider from the list in this brochure and call the office directly. Wilson's Business Health Specialist is also available to answer questions and discuss the options available to meet specific Employee Assistance Program needs.
Call (937) 498-5511.

Please note: Hospitalization or treatment by a psychiatrist is not part of the EAP, but may be covered as part of your healthcare plan.

WILSON HEALTH

Employee Assistance Program Providers

Aspen Wellness Center
317 E. Poplar Street
Sidney, OH 45365
937-493-4673

Catholic Social Services
100 South Main Ave, Suite 101
Sidney, OH 45365
937-498-4593

Family Resource Center
1101 North Vandemark Road
Sidney, OH 45365
937-492-8080 *Serving Youth & Adults

530 South Main Street
Lima, OH 45804
419-222-1168 *Serving Youth Only

720 Armstrong Street
St. Marys, OH 45885
419-394-7451 *Serving Youth Only

Professional Counseling Services
300 James Bohanan Dr.
Vandalia, OH 45377
937-742-7516

Professional Counseling Services
300 James Bohanan Dr.
Vandalia, OH 45377
937-742-7516

Sacks and Psychological Associates
1023 Fair Road
Sidney, OH 45365
937-492-9900
Tuesdays & Wednesdays Only

1485 Commerce Park Drive
Tipp City, OH 45371
937-667-5126
Mondays & Thursdays Only

Tammy Weber-Gilbert, M.S., L.P.C.C.
9000 North Main Street, Suite 333
Dayton, OH 45415
937-771-2977

WellSpace Therapeutics
110 E. Poplar St., Suite 8
Sidney, OH 45365
937-638-4726
wellspace3@gmail.com

24-Hour Crisis Hotline
1-800-351-7347
Tri-County Crisis Center

Wilson Health
915 West Michigan Street • Sidney, OH 45365
WilsonEAP@WilsonHealth.org
www.wilsonhealth.org

WILSON HEALTH

Versailles Medical Massage

MASSAGE THERAPY FOR OUR EMPLOYEES

We are pleased to partner with Versailles Medical Massage to offer our employees Massage Therapy Services on our Wilson Health Campus!

MEDICAL MASSAGE SERVICES -

- By appointment only. Ways to Schedule:
Call or Text (937) 564-7424 (texting is preferred)
or email medicalmassage@wilsonhealth.org
- Sessions Offered:
- 60 Minute Massage - $60
- 30 Minute Massage - $30
- 15 Minute Chair Massage - $15
- Payment Options: Cash, Check, Venmo
or Payroll Deduction

Prices & Location Subject to Change

Meet Your Medical Massage Therapist:

THERESA ANN NELSON, LMT has been providing therapeutic massage services for over 25 years. She is certified in oncology massage and has experience with chair massage, trigger point therapy, reflexology, deep tissue therapy, Swedish massage and geriatric massage.

"My goal is to provide therapeutic massage to aid in the healing as well as provide a sense of well-being and comfort to those patients seeking alternative services. I am available to provide quality, caring and compassionate Massage Therapy services."

– Theresa Nelson, Licensed Massage Therapist, Versailles Medical Massage

Retirement

Wilson Health is dedicated to helping drive better health and financial outcomes today and into retirement. Fidelity Investments administers the retirement plans. All contributions are made on a tax deferred basis. All employees are eligible to participate on their first day of employment and receive Employer Discretionary & Safe Harbor Contribution from Wilson Health beginning day one. For more information, please refer to the 401(k) Plan Overview and if applicable, the 457(b) Summary Plan Descriptions.

Wilson Health provides an employer sponsored retirement savings plan to all active employees through Fidelity Investments, which includes the ability for employees to contribute on a pre-tax basis or after tax via Roth along with an Employer Match (if eligible), a Safe Harbor Employer Paid Contribution, and an Employer Discretionary Contribution. All employees who satisfy the eligibility definition will receive these benefits; please refer to the Summary Plan Description for complete eligibility criteria.

	2024 If employee contributes a minimum of 3% of his/her own money	2024 If employee elects not to contribute any of his/her own money
Employee Deferral	Example Only 3.0%	Example Only 0%
Company Match for eligible employees (Employer Paid)	1.5%	0%
Employer Discretionary	1.5%	1.5%
Safe Harbor (Employer Paid)	3.0%	3.0%
TOTAL	9.0%	4.5%

Matching Contribution: For eligible employees, Wilson Health matches your contributions at 50%, up to a maximum of 3% of your contribution.

Safe Harbor Employer Paid Contribution: For eligible employees, Wilson Health contributes an additional 3% of your base salary each pay period to your retirement account.

Discretionary Contribution: For eligible employees, Wilson Health contributes an additional 1.5% of your compensation each pay period to your retirement account.

Statements: Account statements are provided on a quarterly basis and reflect all activity within the period as well as account balance information. Account information is available on the Fidelity Netbenefits site **www.401k.com**.

Vesting Schedule: Vesting describes ownership of your plan account balances. Please refer to the table below for Wilson Health's 401(k) vesting schedule.

Salary Contributions		Safe Harbor Employer Contribution		Matching & Discretionary	
Years of Service	Vested %	Years of Service	Vested %	Years of Service	Vested %
Immediate	100%	<1 Year(s)	0%	<3 Year(s)	0%
		1 or more years	100%	3 or more years	100%

Tuition Assistance

We offer Tuition Assistance for employees that obtain degrees that support the organization's needs. An employee is eligible 60 days following date of hire.

	Tier 1 Employees	Tier II Employees – (RN Seeking BSN)
Part-Time Employees	$1,500 per calendar year	$1,750 per calendar year
Full-Time Employees	$3,000 per calendar year	$3,500 per calendar year

Here is how much you can receive:

KEY FEATURES OF THE PROGRAM

- ✓ Tuition reimbursement covers the following expenses: tuition, fees, and books for college and university classes. This plan does not reimburse costs for tools, supplies, meals, lodging, or transportation nor does it cover taxes for books or shipping and handling for books. Further, the plan does not reimburse costs for any education that involves sports, games, or hobbies.
- ✓ The participant must submit a copy of the fee bill from the school. The fee bill must include the participant's name, semester enrolling in, specific classes enrolling in, and all the costs incurred for these classes.
- ✓ A grade of "C" or better, "Pass", or "Satisfactory" is required to qualify for tuition assistance. Immediate repayment of course will be required if grade(s) is below a "C", and/or non-passing or unsatisfactory.
- ✓ Recipients of tuition reimbursement are expected to remain working at Wilson Health in a benefits eligible position for a period of 24 months following the last tuition reimbursement payment.

PTO

OBJECTIVE

Paid time off is an important element to balance work and personal time in maintaining employee health and morale.

Paid Time off is an all-inclusive program combining vacation, holiday, personal time off, and short-term illness occasions into one program.

SCOPE

Full-Time and Part-Time employees of Wilson Health.

DEFINITION

PTO	Paid Time Off
Full-Time	72-80 budgeted hours per pay
Part-Time	40-71 budgeted hours per pay

PTO Accrual Table

Years of Service	Accrual Factor	Annual Maximum
0-2 Years	.069	144
2-5 Years	.076	160
5-10 Years	.096	200
10-15 Years	.115	240
15+ Years	.126	264

POLICY

PTO hours begin accruing from the first day worked. PTO is not available for use until 60 calendar days of employment has occurred. If a holiday occurs in the first 60 calendar days of employment the employee may utilize PTO hours for the holiday

PTO hours accrue on all hours paid, including PTO, up to a maximum of 80 hours per pay period. PTO hours do not accrue on overtime or for short-term disability.

Contact Information

Have Questions? Need Help?

Wilson Health is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0829 or via e-mail at BRCMidwest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier Customer Service

Plan	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	UMR	877-233-1800	www.umr.com
Prescription Drugs	TrueScripts	844-257-1955	www.truescripts.com
Dental PPO	Delta Dental	800-524-0149	www.deltadentaloh.com
Vision	EyeMed Vision Care	866-939-3633	www.eyemed.com
Health Savings Account	Fidelity	800-544-3716	www.netbenefits.com
Flexible Spending Account	Fidelity	833-299-5089	www.netbenefits.com
Life and AD&D	Lincoln Financial Group	877-275-5462	www.lgf.com
Voluntary Life and AD&D			
Short Term Disability (STD)			
Long Term Disability (LTD)			
Employee Assistance Program (EAP)	Wilson Health	937-498-5511	www.wilsonhealth.org
401(k)	Fidelity	800-835-5097	www.netbenefits.com
Massage Therapy	Versailles Medical Massage	937-564-7424	NA

Wilson Health DBA Wilson Hospital

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 8 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Therefore, the following deductibles and coinsurance apply:
Wilson Hospital Basic HDHP: Deductible, Individual $2,500 / Family $5,000; Max-out-of Pocket, Individual $2,500 / Family $5,000; Coinsurance, 100 / 0%
Wilson Hospital Premium HDHP: Deductible, Individual $2,000 / Family $4,000; Max-out-of Pocket, Individual $2,000 / Family $4,000; Coinsurance, 100 / 0%
Wilson Hospital PPO Plan: Deductible, Individual $1,500 / Family $3,000; Max-out-of Pocket, Individual $2,500 / Family $5,000; Coinsurance, 80 / 20%
Anthem Basic HDHP: Deductible, Individual $4,000 / Family $8,000; Max-out-of Pocket, Individual $7,000 / Family $14,000; Coinsurance, 75 / 25%
Anthem Premium HDHP: Deductible, Individual $3,000 / Family $6,000; Max-out-of Pocket, Individual $6,000 / Family $12,000; Coinsurance, 75 / 25%
Anthem PPO Plan: Deductible, Individual $3,000 / Family $6,000; Max-out-of Pocket, Individual $7,000 / Family $14,000; Coinsurance, 70 / 30%

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the

person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions
If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Sarah Burmeister
915 West Michigan Street
Sidney, OH 45365
937-498-5502/937-498-5517

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

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

Your Choices
You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

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

Pay for your health services

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

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

Administer your plan

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

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

Run our organization

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

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

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

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

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

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

Other Instructions for Notice
- Effective date: January 1, 2024
- Sarah Burmeister / Human Resource Representative sburmeister@wilsonhealth.org

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Wilson Health About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from Octo ber 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Wilson Health coverage will be affected.

Wilson Health Pharmacy Benefits	For Basics and Premium HDHP Plans After Integrated Med/Rx Deductible
Preventive Generic	100%, no Deductible
Generic	100%, no Deductible
Brand Name Drug	100%, no Deductible
Specialty Drugs	100%, no Deductible
Injectable Drugs	Must be purchased at Wilson Health

Other Retail Pharmacy Benefits	For Basics and Premium HDHP Plans After Integrated Med/Rx Deductible	For PPO Plan After Integrated Med/Rx Deductible
Preventive Generic	100%, no Deductible	100%, no Deductible
Tier 1 – Generic Drug	90% after Deductible	$10 copay (34 day & 90-day supply)
Tier 2 – Preferred Brand	80%, no Deductible	$35 copay (34 day & 90-day supply)
Tier 3 – Non-Preferred Brand	60%, no Deductible	$60 copay (34 day & 90-day supply)
Specialty Drugs Tier 1- Generic Tier 2 - Preferred Tier 3 – Non-Preferred	90%, no Deductible 80%, no Deductible 60%, no Deductible	$60 copay Note: Injectable drugs must be purchased through Wilson Health Pharmacy for PPO Plan

If you do decide to join a Medicare drug plan and drop your current Wilson Health coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Wilson Health and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Wilson Health changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 15th, 2023
Name of Entity/Sender:	Wilson Health
Contact--Position/Office:	Human Resources
Address:	915 West Michigan Street Sidney, OH 45365
Phone Number:	937-498-5502/937-498-5517

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Wilson Health	34-4437944	
5. Employer address	6. Employer phone number	
915 West Michigan Street	937-498-2311	
7. City	8. State	9. ZIP code
Sidney	OH	45365
10. Who can we contact about employee health coverage at this job?		
Sarah Burmeister		
11. Phone number (if different from above)	12. Email address	
	sburmeister@wilsonhealth.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

    All full-time employees working more than 25 hours per week.

  - ☒ Some employees. Eligible employees are:

    Employees working more than 20 hours per week

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Eligible spouse and dependent children up to age 26.

  - ☐ We do not offer coverage.

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

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

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

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