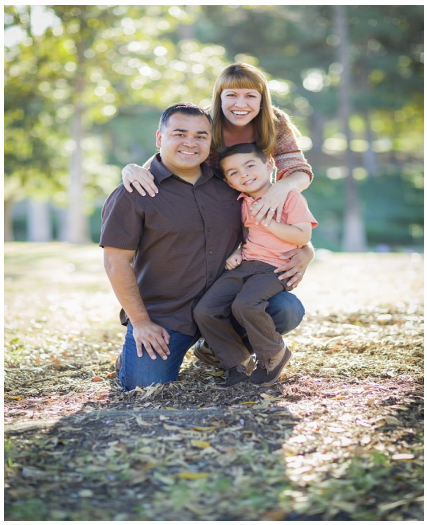
2022

BENEFITS GUIDE

STEPS FOR LIVING WELL.



Spring Arbor
UNIVERSITY

WHAT'S INSIDE

Medicare Notice of Creditable Coverage

If you (and/or your eligible dependents) are currently Medicare eligible or will become Medicare eligible during the next 12 months, the prescription drug coverage that you elect from SAU under the Blue Cross Blue Shield plans are creditable (as valuable) as Medicare's prescription drug coverage.

For more information, review the Plan's Medicare Part D Notice of Creditable Coverage found on page 49.

A CHECKLIST FOR A SUCCESSFUL ENROLLMENT

Step 1: DISCOVER

Your Options

- ☐ **Read this Guide** and keep it handy so you can refer to it as needed. For more details, please visit the Portal to reference the carrier documents.
- ☐ **Attend a meeting on November 8th or** view other resources on the Spring Arbor HR Portal.
- ☐ **Ask Questions.** Contact Spring Arbor Human Resources—SpringArbor.HR@arbor.edu or 517-750-6575 for answers to your questions, if needed.
- ☐ **Sign Up** for a Paycor login if you do not have one.

Step 2: ORGANIZE

For Enrollment

- ☐ **Consider your current benefit coverage and whether or not it will meet your needs for the upcoming year.** For example, are you expecting a major medical expense, such as childbirth or an elective surgery? Is your family financially protected if you can't work due to an accident or illness?
- ☐ **Consider other available coverage.** If your spouse works and has access to benefits through his or her employer, carefully review the coverage available and compare it to SAU's benefits to determine which plan best meets your needs.
- ☐ **Gather information you'll need.** If you are adding new dependents, you will need their dates of birth and Social Security Numbers. You will also need to provide proof of your relationship to Human Resources by the end of Open Enrollment.
- ☐ **If you need additional assistance,** attend an HR Help session. Watch your email

Step 3: ENROLL

Benefit Advisor

- ☐ **Enrollment Process:** Spring Arbor University will be enrolling online through the Benefits Advisor portal provided by Paycor **(www.paycor.com)**. Supporting your wellbeing through your benefit elections is one of the most important decisions you make. Invest the time to do it thoughtfully.
  - **Access Benefits Advisor & Begin enrollment** (review instruction guide as needed)
  - **Verify your personal & dependent information—**make sure you have it to enroll
  - **Navigate the Plan pods & Enroll in a plan**
  - **Make sure to add the appropriate beneficiaries**
  - **Review & Confirm your elections**
  - **Email or Print and Save Your Confirmation Statement**
- ☐ **Enroll by November 22, 2021.** Submit the required information via the Benefits Advisor platform

2022 MEDICAL CONTRIBUTION RATES

MONTHLY RATES	Health Saver 2000	Health Saver 2800	Health Saver 4000
Employee	$111.68	$48.16	$44.46
Employee Child(ren)	$223.38	$96.32	$88.92
Employee + Spouse	$260.22	$112.22	$103.60
Family	$323.90	$139.68	$128.94

ELIGIBLITY FOR SAU BENEFIT PLANS

Who is Eligible

Employees assigned to work 30 hours per week or equivalent teaching load for full-time status classification.

All benefit elections are made independent of one another. If you elect coverage, your dependents are also eligible for medical, dental, vision and voluntary life and AD&D or Aflac insurance coverage. Eligible dependents include:

- ❑ Your legal spouse. A legal spouse is a person of the opposite biological sex to whom you are married at the relevant time by a religious or civil ceremony under the laws of the state in which the marriage was contracted.
- ❑ Your children (including your adopted, biological, and step-children) up to the end of the month in which they turn 26
- ❑ Children up to age 26 for whom you have legal guardianship over. They must live with you, be financially dependent on you, and were under 18 years old when you obtained guardianship.
- ❑ Mentally or physically disabled children of any age if they rely on you for support and became disabled before age 26. Proof of disability will be required under the medical plan.

It is your responsibility to ensure your dependents meet the above requirements. If your dependent becomes ineligible during the plan year, you must notify Spring Arbor University within 30 days. You must also provide Social Security numbers for dependents enrolled in coverage.

When Coverage Begins

Current Enrollees: The coverage options you elect during open enrollment will become effective January 1st.

New Hires: Benefits are effective on the 1st day of the month following your date of hire, unless you are hired on the first of the month. If so, benefits begin that day. You must complete the enrollment process during your initial eligibility period if you want to have coverage. If you fail to enroll during this period, you will only have the company paid Basic Life/AD&D and Long Term Disability coverages.

When Coverage Ends

Your medical, dental and vision benefits coverage will end on the last day of the month and your life and disability coverage the last date in which:

- ❑ You are reclassified to an ineligible status
- ❑ Your employment with SAU ends due to resignation, termination or death; or
- ❑ You stop paying your share of the coverage.

Your dependent(s) coverage ends:

- ❑ When your coverage ends; or
- ❑ For Spouse: Date of the life qualifying event (e.g. divorce) or eligibility through an employer sponsored plan
- ❑ For Legal Child(ren) (up to age 26): The end of the month in which they turn 26.

Gaining Medicare Eligibility

Medicare eligibility requirements and categories vary depending on an individual's situation. Many people are eligible to enroll in Medicare at age 65 and may enroll during the seven-month period surrounding your 65th birthday.

When you become eligible for Medicare, your current coverage and premium costs under Spring Arbor University does not change. Your SAU coverage will be your primary insurance, meaning that claims are first processed through SAU. If any services are covered by Medicare, Medicare will pay as a secondary insurance.

Once enrolled in Medicare, your pretax elections to an HSA must cease.

READY TO ENROLL?

Changing Your Coverage

Spring Arbor University sponsors a program that allows you to pay for certain benefits using pre-tax dollars. IRS regulations state that you cannot change benefit selections during the year unless you experience a qualified change in status or special enrollment period, such as marriage, birth or adoption of a child, or loss of other coverage.

If you experience a qualified change in status, you will be able to make changes to your benefit elections. You will be required to provide verifying documentation for new dependents or events to support the change. For example, if you get married and want to add your spouse to your medical coverage, you will be required to provide a marriage certificate. You are required to submit documentation to Human Resources within **30 days** of the event in order to make changes. Otherwise, you will be required to wait until the next Open Enrollment period to make changes.

All elections will remain in effect through the end of the plan year, December 31st. Because of the limited opportunities to make changes during the year, it is important that you make your elections carefully.

Spring Arbor University: Pre & Post Tax Options

Due to the nature of the Spring Arbor University Section 125 plan, we offer benefit on a pre-tax basis. An additional benefit of making pre-tax benefit selections is that premiums are taken from an employee's gross compensation before any applicable state and federal taxes have been deducted.

Spring Arbor does offer its employees the option to select certain benefits on a post-tax basis. This means that premiums are deducted from an employee's net pay after the applicable state and federal taxes have been deducted.

Please be aware of the difference when selecting benefits in the Benefits Advisor portal.

Adding a New Dependent?

If you are adding a new dependent for coverage, you must provide proof of eligibility to Human Resources by **November 22, 2021.** Failure to provide this information will result in the dependent(s) not being covered in 2022.

SAU and our providers perform plan audits to main in compliance with plan guidelines. If we find you are covering an ineligible dependent, that dependent will be removed (and will not be considered a qualifying event) and you could be found responsible for claims paid while that member was covered.

Proof documents required (copies please; no original documents):

Spouse	Marriage certificate
Child(ren)	Birth certificate listing the employee as the parent; or Birth certificate listing the employee's spouse as the parent (if spouse has not been verified, above proof is also required); or Court paperwork documenting adoption, legal guardianship or foster child relationship; or QMCSO listing the employee as responsible for benefit coverage.

Spring Arbor University

2022 Group Plans Member Enrollment Booklet

GuideStone®

WELCOME TO YOUR GUIDESTONE MEDICAL PLAN

Welcome to the GuideStone® family. We look forward to serving you!

With GuideStone, you're receiving quality, cost-effective, true medical coverage created by Christians specifically for those who serve in ministry.

Let's get started!

TRANSITIONING INTO YOUR NEW PLAN

You are busy with your ministry, so we've done our best to provide you with the tools you need to make a seamless transition to your new medical plan. All the forms and facts you need to enroll in, access and update your coverage are included here.

UTILIZING YOUR BENEFITS

You'll also find valuable resources to guide you in utilizing your benefits. The medical plan road map in this booklet provides an at-a-glance view of your plan's benefits. Plus, you'll find insight on how to make the most of your options, along with information about some bonus benefits that might surprise you.

FINDING ANSWERS

At GuideStone, your satisfaction is our top priority. Answers to your benefit questions are just a tap, click or call away. Quantum is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

- **MyQHealth by Quantum Health: 1-855-497-1230**, *GuideStoneHealth.org* or the MyQHealth - Care Coordinator app.
- **GuideStone Customer Solutions: 1-844-INS-GUIDE** (1-844-467-4843)

"GuideStone cares about the individuals. It's not just about the bottom line or about their own product, but it really is about helping churches and the pastors and staff of those local churches from a perspective of real love and care."

— Terry Hurt, Executive/Worship Pastor
Great Hills Baptist Church, Austin, Texas

NATIONWIDE NETWORKS

MEDICAL PLAN(S)

Health Saver 2000

Effective January 1, 2022

The Health Saver 2000 is an HSA-qualified High Deductible Health Plan, eligible for use with a Health Savings Account (HSA).

	PLAN FEATURES	
In-Network	Deductible for individual coverage	$2,000[1]
	Deductible for family coverage (aggregate deductible)	$4,000[1]
	Plan pays/individual pays (co-insurance)	90%/10% after deductible
	Maximum out-of-pocket (medical and prescription)	$4,000/$8,000
	Primary care or retail clinic visit/ specialist office visit (includes virtual visits)	10% after deductible
	Teladoc™	0% after deductible
	Wellness and preventive care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	10% after deductible
	Outpatient surgery	10% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 10%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 10%
	Urgent care	10% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	10% after deductible
	Chiropractic services (12 visits annually)	10% after deductible
	Mental health/substance abuse: inpatient services	10% after deductible
	Mental health/substance abuse: office visit	10% after deductible
	Vision exam (one exam every 12 months)	10% after deductible
Out-of-Network	Deductible for an individual	$8,000
	Deductible for a family	$16,000
	Plan pays/individual pays (co-insurance)	50%/50% after deductible
	Co-insurance and deductible out of pocket limit for an individual	$28,000
	Co-insurance and deductible out of pocket limit for a family	$46,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	After deductible, $500 co-pay then 50%
	Outpatient surgery	50% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 10%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 50%
	Mental health/substance abuse: inpatient services	After deductible, $500 co-pay then 50%
	Mental health/substance abuse: office visit	50% after deductible

	PRESCRIPTION DRUG PROGRAM[1]		
Retail	30-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-preferred	10% after deductible
Mail Order/ Walgreens	90-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-preferred	10% after deductible
		Diabetic supplies	10% no deductible
		Preferred insulin	$75 no deductible
Specialty	30-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-preferred	10% after deductible

The in-network deductible is met by both medical and prescription drug expenses.

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

A 90-day supply of maintenance drugs can be filled either by Walgreens or by mail order. Prices may vary.

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

GuideStone®

Do well. Do right.®

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network co-insurance maximum.

Deductible for individual coverage — This applies only to an employee who has no dependents included on their coverage. The individual is responsible for paying for medical and prescription drug claim costs up to the plan's individual deductible amount before GuideStone® begins paying claims.

Deductible for family coverage — This applies to an employee who has dependents included on their coverage. The employee and dependents are responsible for paying for medical and prescription drug claim costs up to the plan's family deductible amount before GuideStone begins paying claims for anyone in the family. The family deductible may be met by one individual or by multiple family members' combined claims. This is known as an aggregate deductible.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug.

In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction.
Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit GuideStone.org/Summaries. You may also request printed copies by calling **1-844-INS-GUIDE** (1-844-467-4843) Monday through Friday, between 7 a.m. and 6 p.m. CST.

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Health Saver 2800

The Health Saver 2800 is an HSA-qualified High Deductible Health Plan, eligible for use with a Health Savings Account (HSA). **Effective January 1, 2022**

	PLAN FEATURES	
In-Network	Deductible for individual coverage	$2,800[1]
	Deductible for family coverage (aggregate deductible)	$5,600[1]
	Plan pays/individual pays (co-insurance)	80%/20% after deductible
	Maximum out-of-pocket (medical and prescription)	$4,900 individual coverage only / $8,700/$9,800 individual/family[2]
	Primary care or retail clinic visit/ specialist office visit (includes virtual visits)	20% after deductible
	Teladoc™	0% after deductible
	Wellness and preventive care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	20% after deductible
	Outpatient surgery	20% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 20%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 20%
	Urgent care	20% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	20% after deductible
	Chiropractic services (12 visits annually)	20% after deductible
	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit	20% after deductible
	Vision exam (one exam every 12 months)	20% after deductible
Out-of-Network	Deductible for an individual	$5,600
	Deductible for a family	$11,200
	Plan pays/individual pays (co-insurance)	50%/50% after deductible
	Co-insurance and deductible out of pocket limit for an individual	$25,600
	Co-insurance and deductible out of pocket limit for a family	$35,200
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	After deductible, $500 co-pay then 50%
	Outpatient surgery	50% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 20%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 50%
	Mental health/substance abuse: inpatient services	After deductible, $500 co-pay then 50%
	Mental health/substance abuse: office visit	50% after deductible

		PRESCRIPTION DRUG PROGRAM[1]	
Retail	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible
Mail Order/ Walgreens	90-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible
		Diabetic supplies	20% no deductible
		Preferred insulin	$75 no deductible
Specialty	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible

The deductible is met by both medical and prescription expenses.

For family coverage, one individual cannot be responsible for more than the ACA limit of $8,700.

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

A 90-day supply of maintenance drugs can be filled either by Walgreens or by mail order. Prices may vary.

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

GuideStone®

Do well. Do right.®

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network co-insurance maximum.

Deductible for individual coverage — This applies only to an employee who has no dependents included on their coverage. The individual is responsible for paying for medical and prescription drug claim costs up to the plan's individual deductible amount before GuideStone® begins paying claims.

Deductible for family coverage — This applies to an employee who has dependents included on their coverage. The employee and dependents are responsible for paying for medical and prescription drug claim costs up to the plan's family deductible amount before GuideStone begins paying claims for anyone in the family. The family deductible may be met by one individual or by multiple family members' combined claims. This is known as an aggregate deductible.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug.

In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction.
Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit GuideStone.org/Summaries. You may also request printed copies by calling **1-844-INS-GUIDE** (1-844-467-4843) Monday through Friday, between 7 a.m. and 6 p.m. CST.

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Health Saver 4000

Effective January 1, 2022

The Health Saver 4000 is an HSA-qualified High Deductible Health Plan, eligible for use with a Health Savings Account (HSA).

	PLAN FEATURES	
In-Network	Deductible for individual coverage	$4,000[1]
	Deductible for family coverage (embedded deductible)	$8,000[1]
	Plan pays/individual pays (co-insurance)	80%/20% after deductible
	Maximum out-of-pocket (medical and prescription)	$6,000/$12,000
	Primary care or retail clinic visit/ specialist office visit (includes virtual visits)	20% after deductible
	Teladoc™	0% after deductible
	Wellness and preventive care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	20% after deductible
	Outpatient surgery	20% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 20%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 20%
	Urgent care	20% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	20% after deductible
	Chiropractic services (12 visits annually)	20% after deductible
	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit	20% after deductible
	Vision exam (one exam every 12 months)	20% after deductible
Out-of-Network	Deductible for an individual	$8,000
	Deductible for a family	$16,000
	Plan pays/individual pays (co-insurance)	50%/50% after deductible
	Co-insurance and deductible out of pocket limit for an individual	$28,000
	Co-insurance and deductible out of pocket limit for a family	$46,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	After deductible, $500 co-pay then 50%
	Outpatient surgery	50% after deductible
	Emergency room services: for emergency care only	After deductible, $250 co-pay then 20%
	Emergency room services: care for non-emergencies	After deductible, $250 co-pay then 50%
	Mental health/substance abuse: inpatient services	After deductible, $500 co-pay then 50%
	Mental health/substance abuse: office visit	50% after deductible

	PRESCRIPTION DRUG PROGRAM[1]		
Retail	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible
Mail Order/ Walgreens	90-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible
		Diabetic supplies	20% no deductible
		Preferred insulin	$75 no deductible
Specialty	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-preferred	20% after deductible

The deductible is met by both medical and prescription expenses.

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

A 90-day supply of maintenance drugs can be filled either by Walgreens or by mail order. Prices may vary.

This plan does not constitute “creditable coverage” for Massachusetts residents.

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

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Do well. Do right.®

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network co-insurance maximum.

Deductible for individual coverage — This is the amount an individual is required to pay before benefits begin. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

Deductible for family coverage — This is the amount a family is required to pay before benefits begin. Once this amount is met, the plan will consider all family members to have met their deductibles. One individual cannot contribute more than the individual deductible amount. This is an embedded deductible.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug.

In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction.
Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit GuideStone.org/Summaries. You may also request printed copies by calling **1-844-INS-GUIDE** (1-844-467-4843) Monday through Friday, between 7 a.m. and 6 p.m. CST.

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MEDICAL PLAN BENEFITS

A ROAD MAP TO YOUR GUIDESTONE MEDICAL COVERAGE

Your GuideStone medical plan is more robust and better than ever. Here's a road map to guide you in maximizing your benefits journey.

STOP 1: MYQHEALTH BY QUANTUM HEALTH

Think of Quantum Health as your personal team of nurses, benefit experts and claims specialist who will do whatever it takes to support your unique health care needs. Quantum is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

You have one mobile app, one website and one phone number.

Get to know *MyQHealth*.

- **Download the MyQHealth - Care Coordinator app**
- **Visit *GuideStoneHealth.org***
- **Call 1-855-497-1230**

STOP 2: HELP CENTER

Have a question?

Visit *Help.GuideStone.org* to find answers regarding:

- **Prescriptions**
- **Benefits**
- **Claims**

STOP 3: PREVENTIVE CARE

An ounce of prevention saves you cash and keeps you healthy.

Visit *GuideStone.org/PreventiveCare* to download preventive care information and download your Preventive Schedule at *GuideStone.org/PreventiveSchedule*. Here are some of your covered benefits:

- **Your annual checkup**
- **Preventive mammograms and well-woman screenings**
- **Some cancer, diabetes and blood pressure screenings**

STOP 4: WELLNESS TOOLS AND PROGRAMS

GuideStone's Wellness Tools and Programs page is the place to learn more about your benefits.
Visit *GuideStone.org/WellnessTools* to:

- **Access Teladoc® (telemedicine provider)**
- **Earn cash with SmartShopper®**
- **Take Advantage of Health Coaching**

STOP 5: ADDITIONAL BENEFITS

Your GuideStone medical plan is rich with extras you don't want to miss.
Visit *GuideStone.org/AdditionalBenefits* to discover how to:

- **Access overseas coverage using BCBS Global® Core**
- **Get discounts for products and services using Blue365®**
- **Minimize damage from identity theft with Experian IdentityWorks℠**

MEDICAL AND PRESCRIPTION COVERAGE

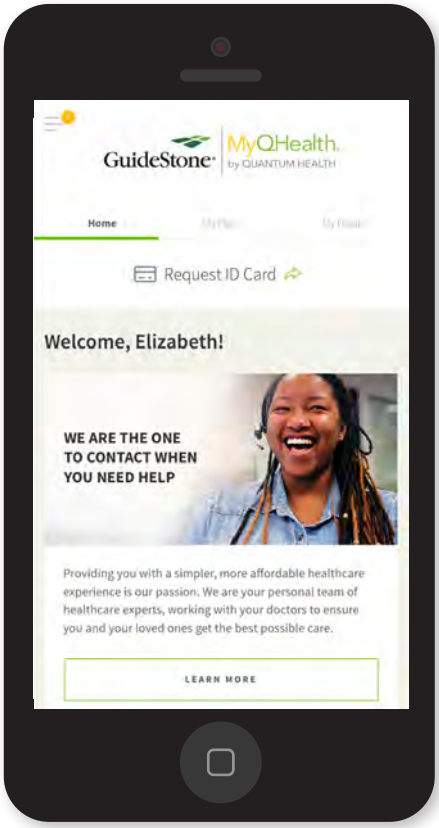
HIGHMARK.

WHAT IF I HAVEN'T RECEIVED MY ID CARD?

If you need to visit the doctor before receiving your ID card, reference the plan information below.

PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans* — **CQM363**
Blue High Performance Network Plans - **N2Q**
GS Group Number for Medicare-coordinating Plans — **OBF363**
Member Number — Your Social Security Number
Benefit Questions — 1-855-497-1230



ORDERING A NEW ID CARD

Employees are encouraged to call Quantum Health directly to request replacement ID cards, print them online at *GuideStoneHealth.org* or access the virtual member ID card in the MyQHealth - Care Coordinator app.

EXPRESS SCRIPTS®

WHAT IF I HAVEN'T RECEIVED MY ID CARD?

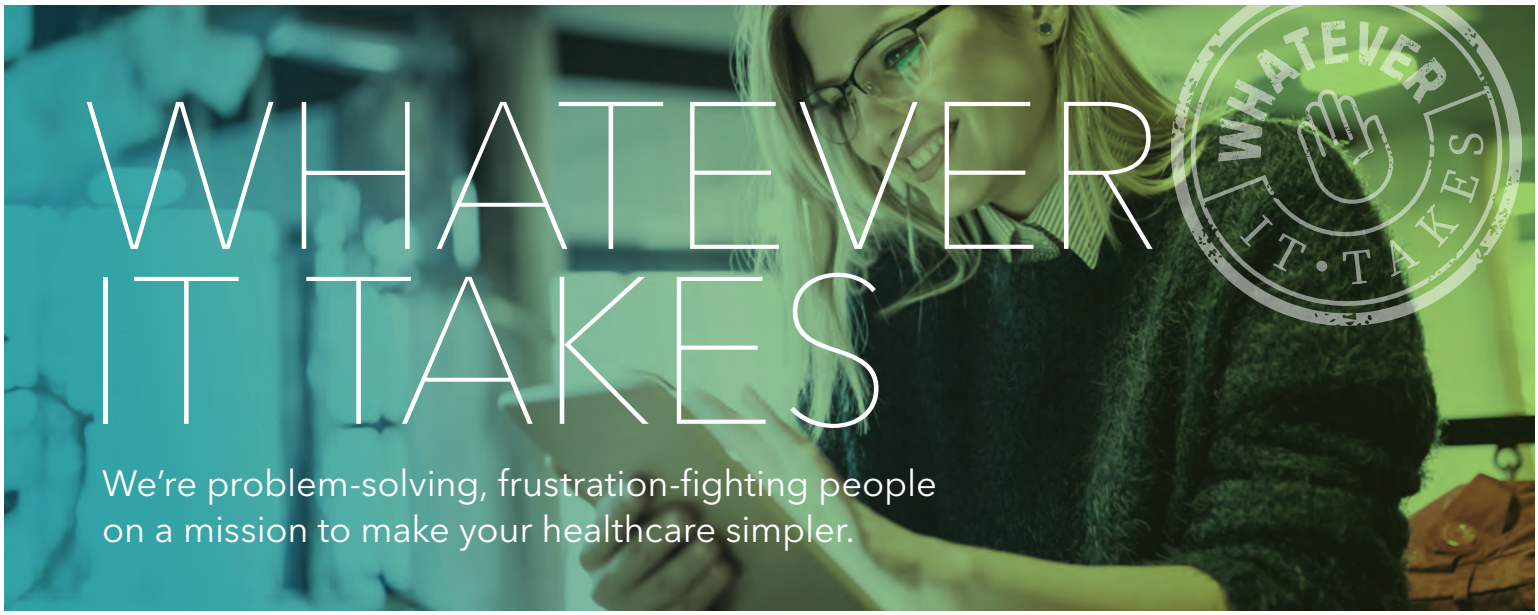
If you need to visit the pharmacy before you receive your ID card, reference the plan information and give it to your provider.

PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans** — **ABSBC01**
GS Group Number for Blue High Performance Network Plans - **ABSBC01**
GS Group Number for Medicare-coordinating Plans — **ABSBC02**
Benefit Questions — 1-855-497-1230
RX Bin for GuideStone Health Plans Except for Secure Health™ (No PCN number required) — **610014**
Rx Bin for Secure Health™ Plans — **003858**
PCN Number for Secure Health™ Plans — **A4**

*All plans except Blue High Performance Network and Medicare-coordinating.

**All plans except Blue High Performance Network, Secure Health™ and Medicare-coordinating.



GuideStone® | MyQHealth® by QUANTUM HEALTH

From replacing ID cards to more complicated matters like claim resolutions, no request is too big or small for your MyQHealth Care Coordinators.

Think of us as your personal team of nurses, benefits experts and claims specialists who will do whatever it takes to support your unique healthcare needs. We're your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

Empowered and resourceful, MyQHealth Care Coordinators do things like:

- Verify coverage
- Provide health-education resources
- Advocate for your care
- Help manage chronic conditions
- Find in-network providers
- Contact providers to discuss treatment
- Answer claims, billing and benefits questions
- Create health-improvement plans
- Help reduce unnecessary, out-of-pocket costs

WHATEVER IT TAKES TO MAKE YOUR HEALTHCARE WORK TO YOUR BENEFIT

We also help confirm precertification for services to make sure you're always covered.

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Genetic Testing
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase over $1500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse

855-497-1230
GuideStoneHealth.org

Download our app
MyQHealth - Care Coordinators

Your Health Benefits
Provider Network: **BCBS PPO, Blue High Performance Network**
Medical Claims Payer: **Highmark BCBS**
Pharmacy Claims Payer: **Express Scripts**

Introducing

Care Finder™

from MyQHealth

GuideStone® | MyQHealth® by QUANTUM HEALTH

Find high-quality, cost-effective, in-network care – all with a single search tool

New to town and need a doctor? Out of town and need a doctor? Looking for the best place to have joint surgery? For all your healthcare research and decisions, now there's only one place you need to go – and it's as close as your computer or mobile device.

Found on your MyQHealth member portal, Care Finder™ helps you find and compare healthcare providers and facilities so you can make informed choices about the care you'll receive. Checking cost and quality rankings in advance can save you hundreds or even thousands of dollars and ensure you receive the best possible care.

Find a PROVIDER

Search by provider name, facility name, ZIP code or procedure. **All search results are in-network***, meaning your insurance provider has negotiated discounted rates for members of your benefits plan.

Compare $ COSTS

Even in-network costs for providers and services can vary significantly. Estimated costs for providers, facilities and procedures are based on the amount health plans have typically paid on claims in your area, from the lowest cost to the highest. The "Fair Price" is the amount you can reasonably expect a medical service to cost.*

Compare QUALITY

These ratings reflect provider and facility performance across multiple criteria, including patient outcomes. Provider Quality Ratings also reflect compliance with standards of care and are updated annually.

Facilities This Doctor May Use	$ At or Below Fair Price	Highest Quality
	$$ Slightly Above Fair Price	Average Quality
	$$$ Highest Price	Lowest Quality

*You should verify a provider's network status prior to your visit, as they sometimes switch networks. While you're at it, you can ask them for an estimate of your anticipated out-of-pocket costs for the procedure.

GuideStoneHealth.org

855-497-1230
(Monday–Friday, 8:30 a.m.–10 p.m. ET)

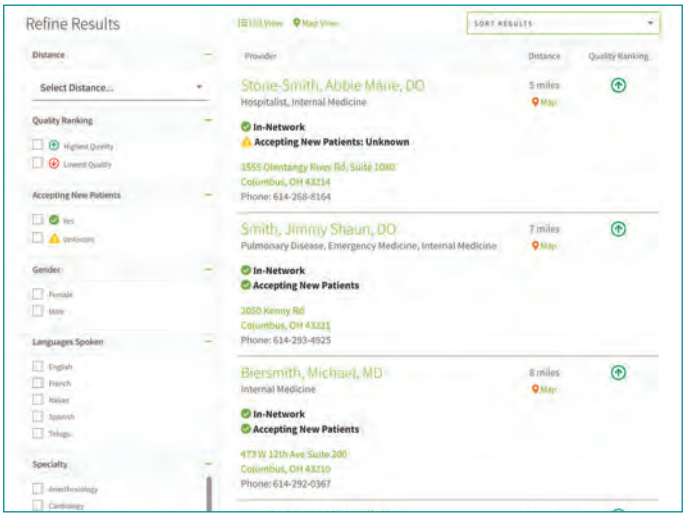
Download the app | **MyQHealth - Care Coordinators**

Quickly find quality, in-network care at a reasonable price.

When it comes to choosing a provider and a facility for common services – imaging, diagnostic procedures, outpatient surgery and more – you have options. With Care Finder™, seeking them out is an easy, informative experience.

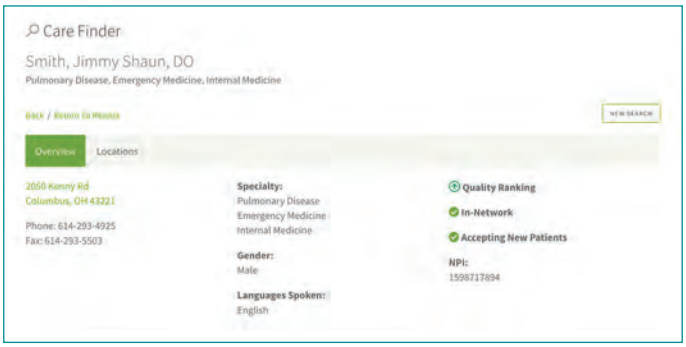
Go to Care Finder without leaving MyQHealth

1. Log on to your member portal or app
2. Go to the **My Plan** section
3. Select **Care Finder** in the menu
4. Begin your search…



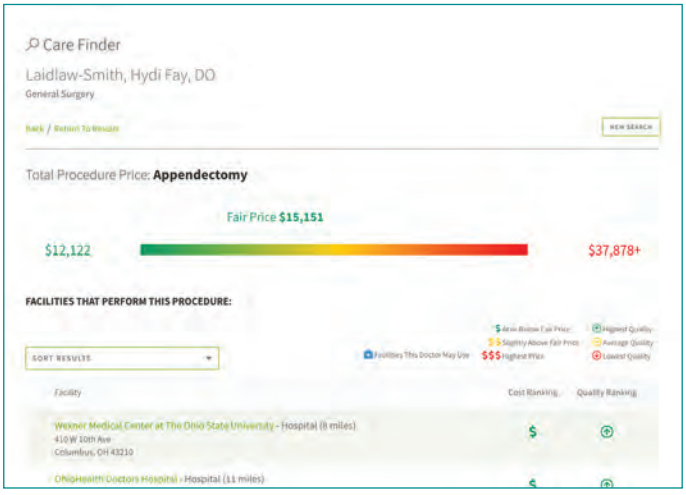
Search for providers and facilities

- Search by provider name, facility name, ZIP code or procedure
- Learn which providers are accepting patients
- Find out how far away they are
- All results are in-network*



Compare cost and quality ratings

- Highest-quality, lowest-cost providers and facilities are shown first
- See a Fair Price estimate for total procedure costs
- Explore three levels of detail for each provider:
  1. Name, location, quality rating and whether they're accepting new patients
  2. Expanded view, including specialties, gender, languages spoken and procedures
  3. The Fair Price for a procedure presented along a market price spectrum



*You should verify a provider's network status prior to your visit, as they sometimes switch networks. While you're at it, you can ask them for an estimate of your anticipated out-of-pocket costs for the procedure.

GuideStoneHealth.org

855-497-1230
(Monday–Friday, 8:30 a.m.–10 p.m. ET)

Download the app | **MyQHealth - Care Coordinators**

WHERE TO GO FOR CARE

HOW TO MAKE THE SMART CHOICE WHEN CHOOSING MEDICAL CARE

You need medical care, but where should you go? Your GuideStone® medical coverage provides five basic options. See which one is right for you.

	Telemedicine (Teladoc®)	Primary Care Physician	Urgent Care	Hospital-based ER	Freestanding ER*
Some Common Conditions	Cold and flu	Regular health screenings	Sprains and strains	Persistent chest pain	Sudden, severe headache
	Bronchitis	Regular health checkups	Sports injuries	Difficulty speaking, altered mental status	Fever in a newborn baby
	Allergies	Fever without a rash	Cuts that require stitches	Sudden or unexplained loss of consciousness	Severe pain
Why Visit	The convenient choice	The in-office choice	The urgent and after-hours choice	The emergency choice	The emergency choice
Cost	$	$$	$$$	$$$$$	$$$$$
Hours	24/7/365	Weekdays only (typically)	8 a.m.–9 p.m. every day (typically)	24/7/365	24/7/365
Wait Time	15-minute call-back time	By appointment only	Varies depending on demand. Online check-in may be an option.	Could wait hours before seeing a doctor	Generally shorter wait times than a hospital-based emergency room

*Freestanding emergency rooms generally do not accept patients delivered via ambulance. Remember, if you are facing a life-threatening situation, always go to the hospital-based emergency room first. Freestanding emergency room treatment can cost thousands more than the same treatment at an urgent care clinic.

URGENT CARE OR FREESTANDING EMERGENCY ROOM? HOW TO KNOW THE DIFFERENCE

Distinguishing between an urgent care facility and a freestanding emergency room can be tricky. It's important to know where you are being treated, because freestanding emergency room treatment can cost thousands more than the same treatment at an urgent care clinic.

Look for the following clues to distinguish the difference. Freestanding emergency rooms:

- **Include the word "emergency" in the facility name**
- **Are never attached to a hospital**
- **Are usually located in more affluent neighborhoods**
- **Offer more complex treatment options than urgent care**
- **Do not accept Medicare and Medicaid patients**
- **Charge much higher prices than urgent care facilities**

BE PREPARED TO ACCESS THE RIGHT CARE

While we all hope never to need emergency, urgent or after-hours care, it is wise to be prepared by:

Registering with *Teladoc.com/GuideStone* now so you can easily access care when you are ill.

Familiarizing yourself with the location of your nearest urgent care clinics.

Learning which hospital emergency rooms are part of your network by visiting *GuideStoneHealth.org*, using the MyQHealth Care Coordinator app or calling 1-855-497-1230.

It is also important to be familiar with your insurance provider's options for treatment. GuideStone members can review the options for seeking treatment and benefit levels in your plan booklet available at *My.GuideStone.org*.

WELLNESS TOOLS AND ADDITIONAL BENEFITS

AVAILABLE IN YOUR GUIDESTONE MEDICAL PLAN

GuideStone's health plans include a rich array of tools to help members maximize your coverage dollars and additional benefits designed to enrich your life.

Here's an overview of the extras included in your plans.*

WELLNESS TOOLS AND PROGRAMS

Staying healthy is easier than ever — you just need the right tools! Learn what's available in your GuideStone Highmark BCBS medical plan.

Visit *GuideStone.org/WellnessTools*.

Access MyQHealth by Quantum Health

Think of MyQHealth as your personal team of nurses, benefit experts and claims specialist who will do whatever it takes to support your unique health care needs. Quantum is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

MyQHealth is just a tap, click or call away.
You have one mobile app, one website and one phone number.

MyQHealth - Care Coordinator app | *GuideStoneHealth.org* | 855-497-1230
Get to know MyQHealth

Save on Health Care

- MyQHealth CareFinder enables you to stay in-network and estimate your cost.
- SmartShopper® allows you to earn cash rewards of up to $1,000 and reduce your out-of-pocket health care costs by shopping for health care procedures with SmartShopper. Access SmartShopper by simply calling 1-866-285-7475 to speak to a personal assistant. SmartShopper is not available with the Blue High Performance Network plans.
- Teladoc® (telemedicine provider) means that you have access to U.S. board-certified doctors, including pediatricians, all day, every day — even holidays. Register today at *Teladoc.com/GuideStone*.

*Global Core, Cigna International and Medicare-coordinating plans are excluded from wellness tools and additional benefits.

Manage Your Health Condition

MyQHealth gives you a comprehensive set of tools, resources, care management, wellness and member solutions to lead your healthiest possible life. Take advantage of programs like health coaching and the Early Steps Maternity program.

Choose a *Blue Distinction® Center* for a high-quality hospital that can lower your chance for complications and shorten your stay. Blue Distinction is a designation awarded by the Blue Cross and Blue Shield Association to hospitals proven to deliver superior results for complicated, costly procedures.

Take Charge of Your Health

Health coaching with MyQHealth can help you with:

- **Healthy eating**
- **Sleep issues**
- **Stress management**
- **Personalized weight-loss plan**
- **Physical activity**
- **And more!**

ADDITIONAL BENEFITS

Your GuideStone medical plan protects more than your health. It also provides for your entire well-being with these additional benefits.

Visit *GuideStone.org/AdditionalBenefits*.

- BCBS Global® Core — Members traveling outside the United States have access to doctors and hospitals in more than 200 countries and territories around the world. Download the BCBS Global Core app or go to *BCBSGlobalCore.com* to help you find doctors, translate medical terms and access emergency care information when you're outside the United States.
- Blue365® — This member discount program can help you save on products and services that are not part of your medical coverage. To browse all the deals, go to *Blue365Deals.com*.
- Experian IdentityWorks℠ — Highmark BCBS provides Experian IdentityWorks to help members who are victims of identity theft. Enrollment is required at *ExperianIDWorks.com/Highmark*. Members must provide their personal information to enroll online or via phone. **Please note:** You will receive an email in December to confirm your coverage for the next year.
- Vision benefit — For individuals in most of GuideStone's comprehensive plans, your vision benefit covers one annual eye exam per covered family member. The coverage does not include the cost of glasses or contact lenses. You must use an in-network provider to receive this benefit. The vision benefit is not available in all plans. Please review your plan booklet for details.

How to Get Started with Teladoc

It's quick and easy to set up your Teladoc® account, but be sure to follow the registration directions below so that your claims will be processed correctly!

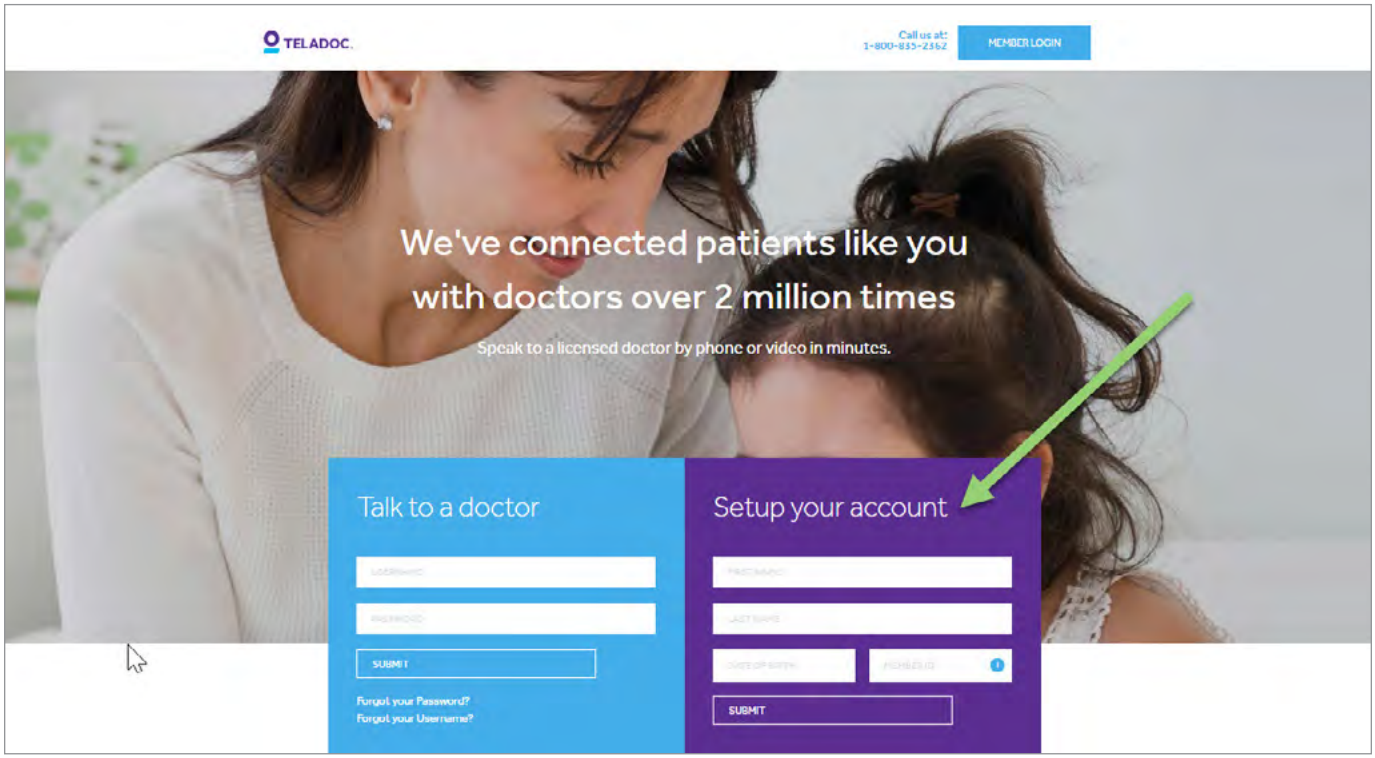
We suggest registering for Teladoc right now. It takes less than 10 minutes and saves vital time when you're not feeling well and need to talk to a doctor. Ready to get started?

How to Register Online at *Teladoc.com/GuideStone* — the Easiest Way to Register

NOTE: Please see the next section if you are registering through *Teladoc.com*.

1. Have your GuideStone® medical plan ID card available when you visit *Teladoc.com/GuideStone* and choose "Set up your account".

2. Provide the following information:
   - First and last name
   - Date of birth
   - Member ID (Located on the back of your GuideStone medical plan ID card. Be sure to include all the letters and numbers.)



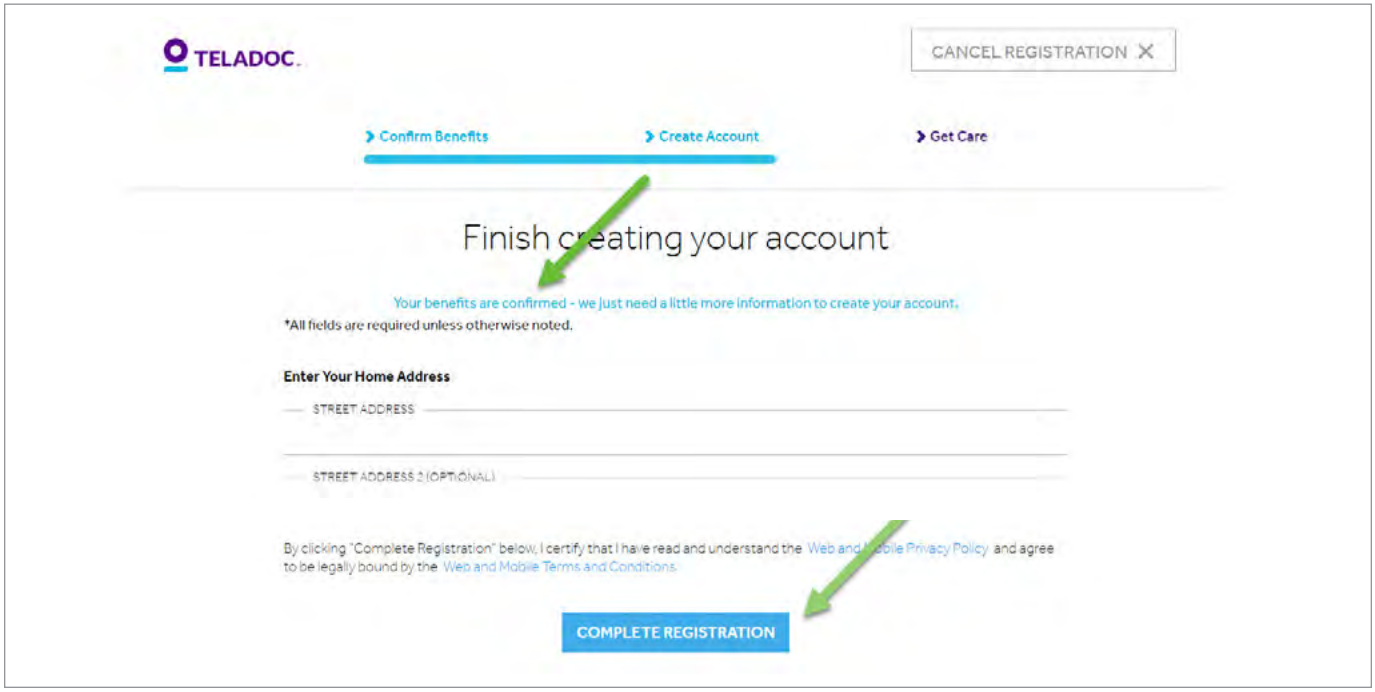
TELADOC™

GuideStone®

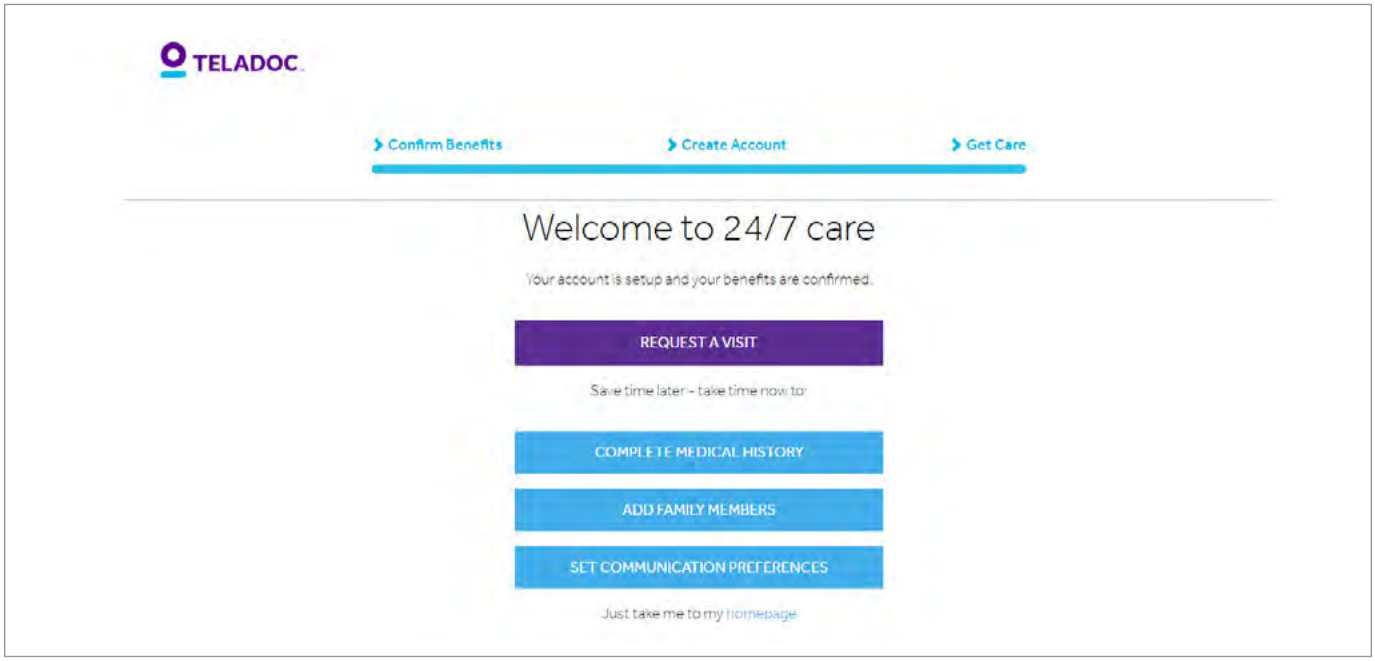
3. Receive a confirmation that your benefits are confirmed.

4. Follow the prompts in the confirmation and provide your:
   - Contact information
   - Username, password and security questions

5. Click “Complete Registration” and you’re finished!



Congratulations, your registration is now complete.



You are now ready to request a consult!

Time-saving suggestion: Complete your medical history, add additional family members and set up communication preferences now to avoid delays when scheduling a consult.

How to Register Online at *Teladoc.com*

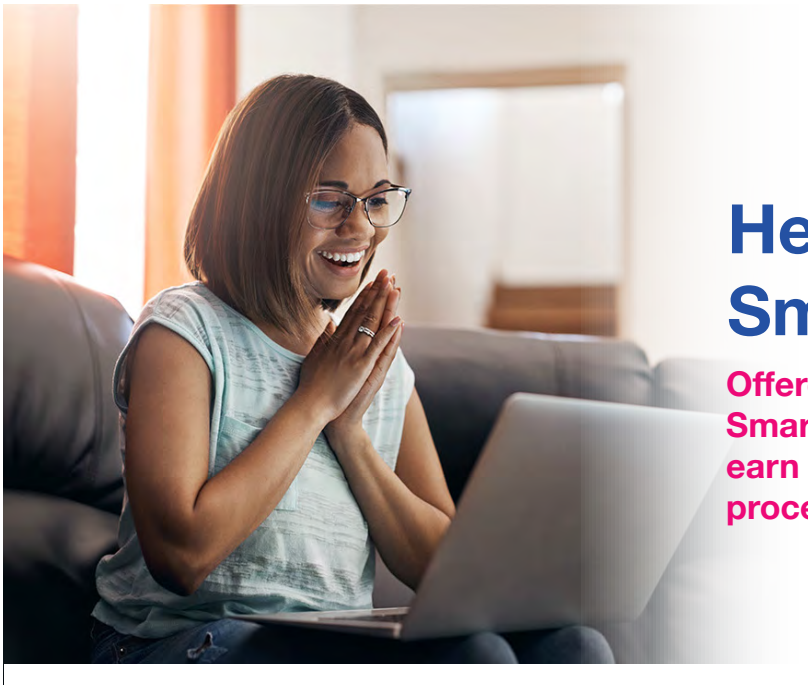
1. Visit *Teladoc.com* and select "Log in/Register".
2. Have your GuideStone medical plan ID card available and choose "Get Started".
3. Provide the following information:
   - First and last name
   - Date of birth
   - ZIP code
   - Email
   - Preferred language
   - Gender
4. Tell them your plan details. It is imperative that you select "Highmark" from the drop-down menu. If this is not correct, your telehealth claims will not be processed correctly and you will be charged a consult fee.
5. Provide your Member ID, which is on the back of your GuideStone medical plan ID card. Be sure to include all the letters and numbers.
6. Select your Highmark plan code 363/865 from the drop-down menu.
7. Review your information and create your username and password.

How to Register by Phone

1. Have your GuideStone medical plan ID card available when you call 1-800-Teladoc (1-800-835-2362).
2. Tell the representative you are in a Highmark Blue Cross Blue Shield (BCBS) health plan.
3. Provide the agent with your Member ID (located on the back of your GuideStone medical plan ID card), including the letters and numbers.
4. Give the agent your first and last name and date of birth.

Talk to a doctor anytime

Visit *Teladoc.com/GuideStone* | Download the app



Hello SmartShopper

Offered by Highmark Blue Cross Blue Shield, SmartShopper saves money and helps you earn rewards when you have routine medical procedures and tests.

How it works

1. SHOP
by phone or online

2. GO
to a cost-effective, in-network location you choose

3. EARN
$25 or more in rewards

Why SmartShopper?

- Prices for the same in-network, high-quality procedure can vary dramatically between locations
- SmartShopper lets you compare convenient, in-network locations and choose the best option
- You save money out-of-pocket and earn a share of the overall savings as a reward
- It's easy to shop online or with a Personal Assistant, who can also schedule your procedure

98% of SmartShoppers would recommend this program to a friend or co-worker.
2019 Survey of SmartShopper Users

Call the SmartShopper Personal Assistant Team at 1-866-285-7475.
Call the SmartShopper Personal Assistant Team Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.

HIGHMARK. GuideStone® Do well. Do right.® SmartShopper®

PREVENTIVE CARE

AN OUNCE OF PREVENTION

SAVES YOU CASH AND KEEPS YOU HEALTHY

Preventive care helps you stay healthy by checking for health problems early when they are easier to manage. Your GuideStone® medical coverage offers a wide array of preventive care services with no out-of-pocket costs to you!

All you have to do is follow your plan's Preventive Care Schedule to receive services such as:

- Annual checkups for adults
- Cancer, diabetes and blood pressure screenings
- Mammograms and well-woman screenings
- Immunizations for children and adults
- Prenatal and fetal screenings
- Routine checkups for infants, children and teens
- Developmental screenings for toddlers
- Special preventive services for at-risk individuals

Find out what's covered in your plan's Preventive Care Schedule by visiting *GuideStone.org/PreventiveSchedule*.

For answers to frequently asked questions about preventive care, go to *Help.GuideStone.org/PreventiveCare*.

PLAN YOUR CARE AND SAVE YOUR CASH

Your GuideStone health plan includes a robust schedule of preventive care services.

Here's a simple five-step plan for accessing them.

1. FOCUS ON THE *PREVENTIVE CARE SCHEDULE*

- Download your Preventive Care Schedule by visiting *GuideStone.org/PreventiveSchedule*.
- Review the services available to you based on your age and gender.
- Get paid to shop for your preventive care mammograms and colonoscopies. Learn About SmartShopper®.

2. STAY IN YOUR NETWORK

- Access provider information at *GuideStoneHealth.org*.
- Go to My Plan>Care Finder to find in-network health care providers in your neighborhood.

3. SCHEDULE AN APPOINTMENT

- Tell the provider you are coming in for preventive services.
- Bring a copy of your *Preventive Care Schedule* with you.

4. PLAN FOR FOLLOW-UP

- Schedule follow-up appointments if necessary.
- Understand that any treatment administered in subsequent appointments will be subject to your standard coverage rules, not the *Preventive Care Schedule*.

5. MONITOR YOUR *EXPLANATION OF BENEFITS* (EOB) STATEMENTS

- Review your statements when they arrive.
- If there are any issues, work with your provider or contact Highmark to assure the procedures were submitted with the accurate information.

What's the difference between preventive care and diagnostic visits?

A Highmark BCBS customer advocate explains how the codes on your claims determine how your benefits are paid at *GuideStone.org/PreventiveClaims*.

GuideStone®

GuideStone.org | 1-844-INS-GUIDE

HEALTH SAVINGS ACCOUNT (HSA) FAQS

How does it work?

If you elect the medical plan, you may be eligible to contribute to a health savings account (HSA). To fully open your account, you will need to complete and submit the County National Form and return it completed to HR. They will use that form to notify payroll of your desired deduction and share it with County National. County National will mail your debit card directly to your home. Should you want to modify your election amount during the year, please contact HR.

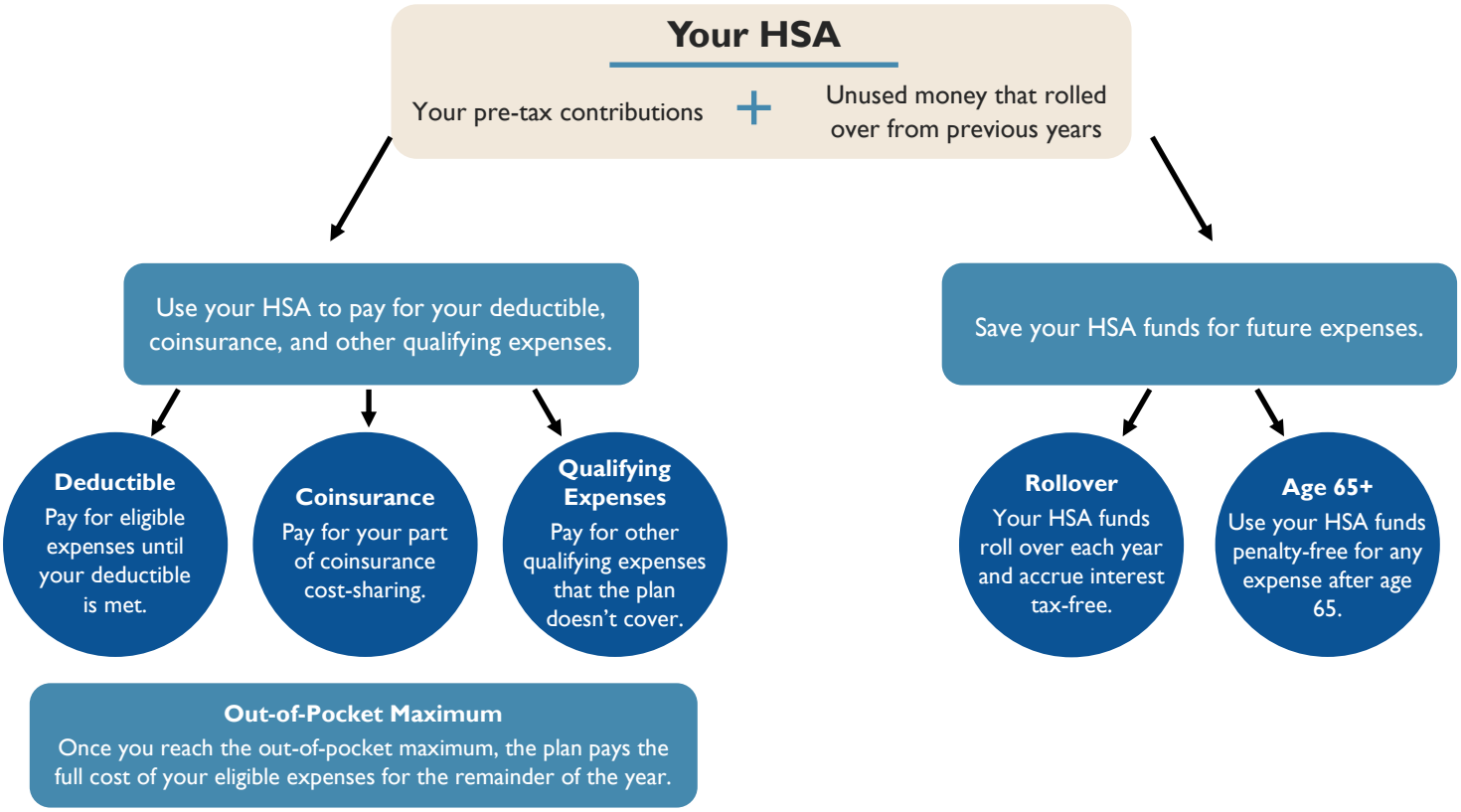
The HSA, allows you to save pre-tax dollars for use on health expenses now or in the future. You can use your HSA to cover health care expenditures, including deductibles, prescriptions, out-of-pocket medical expenses, dental care, and vision care for you, your spouse, and eligible tax dependents. The HSA is yours, regardless of future changes in employment, and any money remaining in your HSA at the end of the year rolls over, allowing you to accumulate significant savings.

Note: The IRS has its own definition of a dependent eligible to use the HSA. For more information, please refer to the section titled, "Distributions from an HSA" of IRS Publication 969.

Key Features:

- Contributions are taken pre-tax from your paychecks and deposited into your account
- Your account earns interest or can be invested to grow tax-free
- Withdrawals for qualified medical expenses are made tax-free
- Funds roll over each year
- 2022 contribution limits:
  - Single coverage: $3,650
  - Family coverage: $7,300
  - Catch-Up contribution (Age 55+): $1,000
- It is not recommended to utilize HSA funds for expenses that will be reimbursed by HRA funds due to possible tax implications according to IRS guidelines.

A Closer Look at the HSA



Can everyone participate in the HSA?

No, not everyone. The Internal Revenue Code says to participate in a HSA, individuals must be enrolled in a "qualified" High Deductible Health Plan (like the one we offer at SAU), they cannot be a dependent on another person's tax return, and they cannot be covered by another non-qualified medical plan. Individuals are not eligible to contribute to both the HSA and a Health Care FSA (or a spouse's Health Care FSA). Additionally, you cannot contribute to a HSA if you have received VA medical benefits in the previous three months, or if you are enrolled in Medicare.

How do I contribute to an HSA?

You can choose to contribute via pre-tax payroll deduction, or you can deposit lump sum amounts (post-tax) into your HSA then take the tax deductions at the end of the year when you file your income tax return.

What kind of health expenses can be paid for with HSA funds?

Eligible or "qualified" expenses are defined by Section 213(d) of the IRS Tax Code. They are the same expenses that are eligible for reimbursement under a Health Care FSA (see IRS Publication 502).

It is not recommended to utilize HSA funds for expenses that will be reimbursed by HRA funds due to possible tax implications according to IRS guidelines.

What if I start an HSA now, but lose eligibility later because I enroll in a non-qualified plan?

You need to be covered by a qualified plan in order to contribute to your HSA. So if you gain coverage under another plan that doesn't qualify, you'll need to stop making contributions to your HSA. You can still use the funds in your HSA for qualified expenses, even if you may not be eligible to contribute to one.

Can I use the money in my HSA to pay for qualified expenses for my spouse or child?

Yes, you can spend your HSA dollars on qualified expenses for yourself, or anyone you claim as a spouse or dependent on your personal income tax—even if that person is not enrolled on your medical plan.

Does the HSA earn interest?

Yes! This is one of the best features of a HSA. Deposits are held in an interest-bearing checking account. Individuals can also choose to invest the funds. The earnings accumulate tax free, and as long as the money in the account is used to pay for qualified expenses, account holders will never pay taxes on the money deposited or the interest or earnings gained. SAU pays the HSA administrative fee on your behalf while you are an active employee.

What happens after I turn 65, or enroll in Medicare?

You will not be able to contribute to an HSA once you enroll in Medicare; however, you will be able to continue to use the money in your account to pay for eligible medical expenses as well as Medicare or long term care insurance premiums. Generally, this means that at age 65 you are no longer able to contribute, since most individuals enroll in Medicare Part A (hospital) at no cost upon turning 65. It is **your** responsibility to stop your HSA deductions.

Do I have to keep records about my HSA?

Yes, you need to keep complete records so you can show the IRS that you've used the money in your account to pay for qualified expenses in the even of an audit. You should keep a record of all deposits and expenditures, and save all receipts. These records are subject to IRS audit, so keep everything in a safe place. SAU nor the bank housing your HSA will have information regarding distributions from your HSA.

What happens if I use the money in my HSA for a non-qualified expense?

Money in your HSA is not taxed when used for qualified health expenses. If you use your funds for non-qualified expenses, a 20% penalty plus regular taxes apply. Once you reach age 65, withdrawals for non-qualified expenses are taxable, but no penalty applies.

Can I use my HSA for Over The Counter (OTC) Medications & Items?

Over-the-counter medications and items are reimbursable without a prescription per the CARES Act of 2020. Menstrual products are qualified expenses as well.

DENTAL

Visiting a dentist every six months might not be your favorite way to spend an hour, but it might be one that saves your life. During routine checkups, dentists look for more than cavities and gum disease—they look for signs of other serious health conditions like heart disease and diabetes.

Mouth maintenance is not only good for your smile; it just might be a life saver!

SAU's dental plan is administered by **Delta Dental of Michigan.** Keep in mind that Delta classifies dentists into three networks.

Delta PPO

- Claim paid based on the Delta approved amount, plus a PPO Provider discount is applied
- Provider cannot balance bill the patient

Delta Premier

- Claim paid based on the Delta approved amount
- Provider cannot balance bill the patient

Non-participating

- Claim paid based on the Delta approved amount
- Provider can balance bill the patient for the difference between their fees and Delta's approved amount

2022 RATES

MONTHLY RATES	Dental	Vision
Employee	$43.06	$6.76
Two Person	$81.14	$12.83
Family	$161.06	$18.84

ITEM/SERVICE	COVERAGE
Deductible (waived for Tier 1 and Tier 4)	$50 per person (max of $150 per family)
Annual Maximum Benefit (does not apply to Tier 1 or Tier 4)	$1,000 per person
Maximum Carryover	$1,200 ($350 added each year one service of less than $500 paid that year)
Orthodontia Lifetime Maximum	$1,000 per person
Tier 1: Diagnostic & Preventive Services	Plan pays 100% / You pay $0
Tier 2: Basic Services	Plan pays 80% / You pay 20%
Tier 3: Major Services	Plan pays 50% / You pay 50%
Tier 4: Orthodontic Services (to age 19)	Plan pays 50% / You pay 50%

VISION

Caring for your vision is critical. An exam can detect if corrective lenses are needed so you can enjoy reading, watching TV, or working at your computer.

The vision plan is administered by **EyeMed** and Insight is the participating provider network.

- ☑ **$10 copay for an exam** (up to a $40 reimbursement for a non-Insight provider)
- ☑ **40% discount on glasses** (frames, lenses and 20% off on lens enhancements)
- ☑ **15% discount on laser correction**

The chart includes only a summary of in-network coverage—for more details, as well as out-of-network reimbursement options, refer to the carrier documents.

For additional discounts, create an account at eyemed.com, click on special offers to get your savings code.

ITEM/SERVICE	COVERAGE
Exam (every 12 months)	$10 copay
Glasses (every 12 months)	$15 copay
Frame (every 24 months)	$150 allowance 20% discount on remaining balance
Contacts (instead of glasses; every calendar year)	Up to $55 copay (fitting and evaluation) $150 allowance

FLEXIBLE SPENDING ACCOUNT (FSA)

SAU offers Flexible Spending Accounts through **iSolved Benefits**. Flexible Spending Accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. You select a dollar amount that is deducted pre-tax from your gross pay each pay period to fund your account.

SAU offers full-time employees three types of flexible spending accounts: Health Care Flexible Spending Account, Limited Medical Flexible Spending Account and Dependent Care Flexible Spending Account.

Here's how you save:

- The amount you contribute to a FSAs is deducted from your paycheck before Federal, State, local and Social Security taxes are withheld.
- When you have an eligible expense, you use money from (or are reimbursed from) your account(s) and the money isn't taxed.

Health Care FSA

The **Health Care FSA** allows you to pay for eligible expenses not already covered by a medical/prescription drug, dental or vision plan, such as co-pays and deductibles. You are not eligible for the Health Care FSA if you are enrolled in a high deductible health plan. You may contribute up to $2,750* to this account.

Limited Purpose FSA

If you enroll in the HMO medical plan, you are not eligible to elect the Health Care FSA. Rather, you can elect this account as it is compatible with High Deductible Health Plans. It allows you to set aside dollars to use for dental and vision expenses. You may contribute up to $2,750* to this account.

Dependent Care FSA

You can contribute up to $5,000 (a minimum of $100) to a Dependent Care FSA to pay for the day care of your dependent children under the age of 13 and dependents of any age who are incapable of self-care, who live with you at least eight hours per day, and who are claimed as dependents on your income tax return.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or overnight care, nursing home care, or for babysitting when you are not at work.

Note: If you contribute to a Dependent Care account, you must file an IRS form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Important!

The balances in your Health Care and Dependent Care FSAs are subject to "use it or lose it" rules. You should estimate your health and dependent care expenses *carefully* when deciding how much money to put in the Flexible Spending Accounts. The IRS requires that you forfeit any FSA amounts you do not use. Active employees will have until March 31, 2022 to submit expenses for the 2021 plan year. There is a $2.50 per month fee to open these accounts. SAU covers the remaining fees.

	Reimbursement Account Comparison			
	Health Savings Account	**Health Care FSA**	**Limited Purpose FSA**	**Dependent Care FSA**
Eligibility	Employees enrolled in a SAU medical plan	Employees not enrolled in a SAU medical plan.	Employees enrolled in a SAU medical plan	All employees who will have eligible dependent care expenses.
Tax-Advantaged	Yes	Yes	Yes	Yes
Balance Rollover	Yes	No	No	No
Earns Interest	Yes	No	No	No
Eligible Expenses	Medical, Prescription Drugs, Dental, and Vision	Medical, Prescription Drugs, Dental, and Vision	Dental and Vision	Dependent Care
Contribution Limit	Single: $3,650 Family: $7,300 Age 55+ Catch-Up: $1,000	$2,750	$2,750	$5,000
Investment Option	Yes	No	No	No

* Check with HR regarding the most updated IRS contribution limits.

LONG TERM DISABILITY

SAU provides a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. This coverage is provided **free** to employees and is administered by **Mutual of Omaha**.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. Review the certificate/benefit book for details on these and other important provisions.

Item	LTD Benefit
Monthly Benefit	60% of your monthly pre-disability earnings up to a maximum of $7,500 per month. Earnings are defined as gross monthly income in effect just prior to your date of disability, including pre-tax deductions. It does not include overtime pay, bonuses, commissions, other extra income or income received from sources other than your Employer. Your benefit may be reduced by deductible sources of income and disability earnings.
Elimination Period	You must be disabled 90 days during a 180 accumulation period. You must not be continuously disabled for the 90 day elimination period in order for you to be eligible for this benefit.
Benefit Period	If you become disabled prior to age 61, benefits are payable up to age 65, Social Security Normal Retirement age or 3 to 6 years, whichever is longest. Benefits are limited to 24 months in a person's lifetime for mental/nervous or substance abuse conditions.
Pre-existing Conditions	Benefits are not payable for a disability due to a pre-existing condition that begins within 12 months of your effective date of coverage. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medications during the 3 months prior to your effective date of coverage.

ABOUT THIS GUIDE

This Guide contains the benefit overview details of the full benefits package offered to you as an SAU employee. For more information, visit the Portal. Please contact Human Resources if you have any questions.

Not all benefits, limitations and exclusions of the benefit programs are listed. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. SAU reserves the right to amend, modify or terminate any plan at any time and in any manner.

VOLUNTARY SHORT TERM DISABILITY

Our Short Term Disability (STD) plan pays you income if you are disabled from work due to a non-work related illness or injury. This is a **voluntary option paid for by the employee** and is administered by **Mutual of Omaha**.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. Review the certificate/benefit book for details on these and other important provisions.

Item	Benefit
Weekly Benefit	70% of your weekly pre-disability earnings up to $1,000 with a $25 minimum. Earnings are defined as base earnings not including commissions, overtime pay, bonuses, or any other special compensation not received as basic salary.
Elimination Period	21 days for disability due to an accident; or 21 days for disability due to an illness;
Benefit Period	Benefits are payable for up to 10 weeks.
Definition of Disability	You are disabled when Mutual of Omaha determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in weekly earnings due to the same sickness or injury. You must be under the regular care of a physician in order to be considered disabled.

GROUP LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

It is important to give serious consideration to what expenses and income needs your dependents would have if something happened to you. Life Insurance will pay your "beneficiary" a benefit in the event of your death. To ensure that all employees have a basic level of protection, SAU provides all eligible full-time employees with free basic life and AD&D insurance that is equal to one times your annual salary up to a maximum of $50,000. You are automatically enrolled if you are eligible.

Life benefits begin to reduce for employees age 65 and older. Please see the carrier certificate for details.

Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

According to the IRS regulations, the value of employer-provided group term life insurance over $50,000 is taxable income. This "additional taxable income" is subject to social security and Medicare taxes and must be reported on the employee's W-2 Form as "other compensation".

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

You have the opportunity to purchase additional life insurance for yourself, spouse and your children through post-tax payroll deductions. In order to purchase coverage for your spouse or children, you must first purchase Voluntary Coverage for yourself.

The amount of insurance on your dependent(s) will not exceed 50% of your election. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.

Please note: Employee and spouse coverage is reduced 35% at employee's age 70, and 55% at age 75. Benefits will not be paid if the death results from suicide within 2 years after voluntary life insurance is effective. You must be actively at work on the effective date of your voluntary life coverage for your coverage to be effective. If you are not actively at work on that date, coverage will go into effect when you return to active work. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

Individual	Voluntary Coverage Amounts	Do You Need to Provide Medical Information (Evidence of Insurability)
Employee	Any multiple of $10,000; maximum of $500,000 or 7x annual earnings; minimum of $10,000	Yes, if you: • are electing in excess of $200,000; or • want to increase your coverage at future open enrollment periods; or • do not elect coverage when first eligible and later decide to elect coverage Coverage does not become effective until your request has been approved by United of Omaha Life Insurance Company.
Spouse	$5,000 minimum up to $250,000, not to exceed 100% of voluntary employee life coverage amount	Yes, if you: • are electing in excess of $50,000; or • do not elect coverage when first eligible and later decide to elect coverage Coverage does not become effective until your request has been approved by United of Omaha Life Insurance Company.
Child(ren)	$2,500 increments up to $10,000	No

Voluntary Life and AD&D continued.

Cost of coverage is based on your age and status of tobacco use. The cost for your spousal voluntary life election is based on the employees age.

EMPLOYEE PREMIUM TABLE FOR NON-TOBACCO USERS (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
30 - 34	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
35 - 39	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40 - 44	$1.05	$2.10	$3.15	$4.20	$5.25	$6.30	$7.35	$8.40	$9.45	$10.50
45 - 49	$1.75	$3.50	$5.25	$7.00	$8.75	$10.50	$12.25	$14.00	$15.75	$17.50
50 - 54	$2.90	$5.80	$8.70	$11.60	$14.50	$17.40	$20.30	$23.20	$26.10	$29.00
55 - 59	$5.00	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00	$45.00	$50.00
60 - 64	$6.90	$13.80	$20.70	$27.60	$34.50	$41.40	$48.30	$55.20	$62.10	$69.00
65 - 69	$10.50	$21.00	$31.50	$42.00	$52.50	$63.00	$73.50	$84.00	$94.50	$105.00
70+	$22.00	$44.00	$66.00	$88.00	$110.00	$132.00	$154.00	$176.00	$198.00	$220.00

EMPLOYEE PREMIUM TABLE FOR TOBACCO USERS (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50
30 - 34	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
35 - 39	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00
40 - 44	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25	$22.50
45 - 49	$3.70	$7.40	$11.10	$14.80	$18.50	$22.20	$25.90	$29.60	$33.30	$37.00
50 - 54	$6.10	$12.20	$18.30	$24.40	$30.50	$36.60	$42.70	$48.80	$54.90	$61.00
55 - 59	$9.40	$18.80	$28.20	$37.60	$47.00	$56.40	$65.80	$75.20	$84.60	$94.00
60 - 64	$10.60	$21.20	$31.80	$42.40	$53.00	$63.60	$74.20	$84.80	$95.40	$106.00
65 - 69	$14.40	$28.80	$43.20	$57.60	$72.00	$86.40	$100.80	$115.20	$129.60	$144.00
70+	$26.00	$52.00	$78.00	$104.00	$130.00	$156.00	$182.00	$208.00	$234.00	$260.00

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.25	$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50
30 - 34	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
35 - 39	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
40 - 44	$0.53	$1.05	$1.58	$2.10	$2.63	$3.15	$3.68	$4.20	$4.73	$5.25
45 - 49	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75
50 - 54	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
55 - 59	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$25.00
60 - 64	$3.45	$6.90	$10.35	$13.80	$17.25	$20.70	$24.15	$27.60	$31.05	$34.50
65 - 69	$5.25	$10.50	$15.75	$21.00	$26.25	$31.50	$36.75	$42.00	$47.25	$52.50

ALL CHILDREN PREMIUM TABLE			
(12 PAYROLL DEDUCTIONS PER YEAR)			
$2,500	**$5,000**	**$7,500**	**$10,000**
$0.44	$0.87	$1.31	$1.74

SUPPLEMENTAL INSURANCE—AFLAC

Sometimes, the unexpected occurs. Supplemental worksite coverage are affordable ways to protect yourself financially from unforeseen medical emergencies. These products are administered by Aflac and are paid for through post-tax payroll deductions. Each of these products can be purchased independent of the other, and of other SAU benefits. They are all portable in the event you leave SAU. Pre-existing conditions may apply. Please review the full benefit details.

We know how important it is for you to receive you preventive care services, so these plans each include a Wellness Benefit (chest x-ray, colonoscopy, mammography, Pap smear, etc.).

Aflac Cancer Care

When faced with cancer, the cost of treatments can add up very quickly! This coverage allows you to receive a lump sum payment to help cover those costs. Whether it is chemotherapy or a second surgical opinion, simply make a claim to Aflac. Coverage can be purchased for you, your spouse and your children.

Aflac Accident Insurance

Aflac's voluntary accident insurance gives you something to help when accidental injuries occur. This coverage can help employees meet out-of-pocket expenses (e.g. deductibles and coinsurance and other extra bills). You have coverage on and off the job for a wide variety of injuries and accidents such as home falls and kid's sports injuries. Benefits are paid directly to the team member. There are no limits on the number of accidents the policy covers and rates do not increase as you age. If you take coverage yourself, you can cover other family members as well.

Aflac Hospital Choice

Hospital Choice coverage is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Hospital Choice lump sum benefits are paid directly to you based on the amount of coverage listed on the schedule of benefits, regardless of the actual cost of treatment. Coverage is available for you, your spouse and your children providing you elect coverage for yourself.

Aflac Plus Rider—Critical Illness

This coverage is designed to help employees offset the financial effects of a catastrophic illness. Benefits are based on the amount of coverage in effect on the date of a diagnosis for such illnesses as heart attack, stroke or coma. The benefit can be used however you choose, for the expenses your health insurance doesn't cover. You can keep this coverage even if you change employers and full benefits are available to all family members.

For Further Information:

Contact: Chris Bouldrey
Phone: 269-998-9950
Email: chris_bouldrey@us.aflac.com

Please visit the Aflac website dedicated to Spring Arbor University Employees below for further details and premium information:
https://spark.adobe.com/page/2rr0gKVXS9ehY/

403B RETIREMENT PLAN—TIAA

Employees may begin to contribute at the time of hire or any time after. SAU will contribute 5% of a benefit eligible employee's gross wages after you have one year of service with SAU. Newly benefit eligible employees with a current TIAA account and can provide proof of such, SAU will begin to contribute at time of hire. At age 55 and above or 10 years of service, SAU will contribute 6% for benefit eligible employees. Contact Human Resources for further details.

ADDITIONAL SAU BENEFITS

Employees may be eligible for the following additional benefits. See the SAU Employee Manual for details on eligibility (located on SAU portal).

- Paid time off
- Sick Leave
- Jury Duty
- Bereavement Leave
- Holidays
- FMLA Leave
- Moving Expense Reimbursement
- Dining Commons Discount
- Tuition Discount
- Bookstore Discount
- Use of Fieldhouse & fitness room
- Admission to Athletic Events

BENEFITS TO MEET THE NEEDS OF YOU & YOUR LOVED ONES

Working Together for Better Health

It is because of our employees that we are a successful organization. Each year, we design our benefits program offering to ensure that we provide all the essential resources for you and your family. It is our priority to help our employees have what they need to live a healthy, happy life.

We strive to offer a variety of benefit choices and resources to help you be the best person and employee. Take time to learn and understand what is available. These services are available to help you live and manage in today's complex world.

Review this guide for more information on the benefits available for you and your loved ones in 2022. Refer back to this guide throughout the year when you have additional questions on your benefits.

CONTACT

CARRIER	PHONE	WEBSITE
Blue Cross Blue Shield Highmark Medical	(855) 497-1230	highmarkbcbs.com
Guidestone **Quantum Health** Member Services	(855)497-1230	Guidestonehealth.org
Express Scripts Prescription Drugs	(855) 497-1230	www.express-scripts.com
Walgreens Pharmacy Specialty Prescription Drugs	(855) 497-1230	www.Walgreens.com/pharmacy www.alliancerxwp.com
Teladoc 24/7 doctor visits	(800) Teladoc (835-2362)	www.teladoc.com
Delta Dental of Michigan Dental Dental	(800) 524-0149	www.deltadentalmi.com
EyeMed Vision (Insight network)	(866) 723-0513	www.eyemed.com
Mutual of Omaha Life, AD&D and Disability	(800) 877-5176	www.mutualofomaha.com
isolved Benefit Services Flexible Spending Accounts (FSA)	(800) 300-3838	www.isolvedbenefitservices.com
County National Bank Health Savings Account (HSA)	(888) 322-1088 (517) 439-4300	www.countynationalbank.com
Aflac Accident, Hospital Choice, Accident, Cancer	(269) 998-9950 E-mail: Chris_bouldrey@us.aflac.com	https://spark.adobe.com/page/2rr0gKVXS9ehY/
Human Resources General inquires	x1576 E-mail: SpringArbor.HR@arbor.edu	The Portal

LEGAL NOTICES

Midyear Election Changes to Pre-Tax Benefits

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

HIPAA Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Marketplace coverage) 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 towards 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.

To request special enrollment or obtain more information, contact Human Resources.

Summary of Material Modification

The information in this document and in the benefit guide applies to the **Spring Arbor University plan**. This information meets the requirements for a summary of material modification.

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the **Benefit Guide,** the Benefit Plan Notice Requirements document, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. **Spring Arbor University** reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a post-secondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext 2131

INDIANA – Medicaid
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
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – 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

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – 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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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, 2021, 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

Important Notice from Spring Arbor University About Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Spring Arbor University 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. **Spring Arbor University has determined that the prescription drug coverage offered by the Spring Arbor University 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 October 15th through December 7th.

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

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

If you decide to join a Medicare drug plan, your current Spring Arbor University coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Spring Arbor University coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 Spring Arbor University 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 **Spring Arbor University** 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 2021
Name of Entity/Sender:	Spring Arbor University
Contact--Position/Office	Human Resources
Address:	106 E. Main St.
Phone Number:	517-750-6575

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

Now that key parts of the health care law have taken effect, there is 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. For 2022, open enrollment for health insurance coverage through the Marketplace begins November 1, 2021 and ends December 15, 2021, for coverage starting January 1, 2022.

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 9.86% of your household income for 2022, 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.

If you work full-time and are eligible for coverage under your employer's health plan, the plan satisfies the minimum value standard, and the cost is intended to be affordable based on employee wages.

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 your Human Resource department at 517-750-6428.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. 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.

[1] A health plan provides "minimum value" if the plan's share of the total allowed benefit costs covered by the plan is at least 60% of such costs.

MI No Fault and Auto Coordination

The medical plans offered by Spring Arbor University do meet the requirements to be considered qualified health coverage under the Michigan no-fault law. This is because the plans (1) do not exclude or limit coverage for injuries related to motor vehicle accidents; and (2) have an annual deductible of $6,000 or less per individual.

When coverage is "coordinated" between your auto policy and your employer-sponsored health plan, the health plan pays first for auto-related medical claims. The auto insurer will require you to provide documentation proving that your health plan will pay first, in order to elect coordinated coverage. As of January 1, 2022, SAU's group health plan is NOT considered 'coordinated' coverage, but this does not necessarily mean that other health coverage (i.e. spouse's) is not 'coordinated'. Be sure to ask the question and confirm this detail before you have a discussion with your auto insurer agent.

If coverage between the auto policy and the health plan is "uncoordinated," then the PIP coverage will pay claims first. Spring Arbor University's health plan is considered 'uncoordinated' and will take a secondary stance regarding auto-related medical claims.

SECONDARY: This means Spring Arbor University's health plan will pay for covered medical claims only after auto PIP coverage. In the absence of PIP, the plan will pay medical benefits per the terms of the policy. It may not cover all medically-recommended services, with all providers, and it will not cover expenses related to assistance with the activities of daily living.