Employee Benefits 2022

Sarah Bush Lincoln

Trusted Compassionate Care

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TOP THINGS TO KNOW ABOUT YOUR 2022 BENEFITS

This employee benefit booklet includes information about changes for the 2022 plan year and enrollment period which is open November 8 to November 19. Please read this carefully to understand your benefits, wellness resources, and responsibilities for 2022.

Here are the key benefit changes for 2022:

Addition of Several New Voluntary Benefits:

This year brings many NEW additions to our voluntary benefits, which include accident insurance, hospital indemnity insurance, enhanced critical illness policies and universal life insurance with a long-term care attachment. Be sure to check out the "Voluntary Benefits" section to learn the details on each new benefit.

New Employee Discount Program: PerkSpot

PerkSpot is a one-stop-shop for exclusive discounts at many of your favorite national and local merchants! PerkSpot is completely free to all employees and family, and may be accessed with any device: desktops, tablets, and phones. Start saving by signing up or logging in at sbl.perkspot.com using your legal name. Access thousands of discounts in dozens of categories, updated daily. Keep an eye out for newly featured discounts in PerkSpot's weekly email.

Health Plan – Premium/Deductible

The transition to Consociate has resulted in a plan design that reduces total benefit expense through maximizing use of SBL providers and negotiating better discounts with Tier 1 providers. SBL has been successful in slowing the growth in health plan claims expenses due to this change, which results in our ability to maintain the same copay/deductible levels and plan premiums. While many companies across the nation, are experiencing 5 to 7 percent increases in employee-paid premiums and deductibles, SBL maintains the 2021 rates for the upcoming 2022 benefit year.

Wellness Rewards

The requirements to qualify for Wellness rewards in 2023 remain the same (i.e. Wellness Screen, PCP Wellness Statement and Nicotine-free status). TheWellness Team will be introducing a new platform called Virgin Pulse. This platform will help you achieve your health goals, while having a fun and engaging experience with resources right at your fingertips! Check out the new Wellness Portal starting in January 2022.

Flexible Spending Account (FSA)

It is not yet been announced whether the 2021 FSA contribution limit of $2,750 will be increased for 2022. Human Resources will communicate through The Daily Charge if notified of any change in the limit. Remember to make your elections for the FSA plan during open enrollment to be eligible for the pre-tax savings. If not elected during the benefit enrollment, the FSA will default to zero.

2022 BENEFIT ENROLLMENT INFORMATION

BENEFIT ENROLLMENT

The online Benefit Enrollment period is **November 8 to November 19, 2021**. *Instructions on back cover.*

If you do not complete your benefit enrollment by November 19, 2021, your 2021 elections will be moved into 2022, ***with the exception of your Flexible Spending Account (FSA), which will default to zero.***

PLAN ENROLLMENT RULES

Enrollment for 2022 is open to all full-time (70+ hours per pay period) and part time (40–69 hours per pay period) employees and eligible dependents.

All benefit elections remain in effect for the 2022 calendar year unless there is a change in family status or a HIPAA- qualifying event (must notify HR within 30 days of event.) All employees adding a spouse or civil union partner are required to provide appropriate documentation (certificate of marriage or civil union.) Anyone new to the plan must complete the wellness screening and PCP statement, by the 10th of their benefit eligibility month.

SCHEDULING AND ENROLLMENT PROCESS

To better communicate and facilitate our benefits enrollment program, we have partnered with EOI Service Company, LLC, a firm that has specialized in employee benefits communication and enrollment services for more than 40 years. EOI's team of professional benefit counselors will provide enrollment, consultation, and communication services to ensure that employees are educated and enrolled in their selected benefit programs. Each benefit-eligible employee will have an option to speak with a benefit counselor to complete their enrollment elections.

To schedule an appointment, employees can visit SBL.MyBenefitsAppointment.com or call 814-498-4775, Monday through Friday, 8 am to 5 pm, CT. If employees are not able to speak with a counselor, they can log on to Benefits Express to enroll.

Open Lab Sessions – Enrollment Support

A Human Resources representative will be available to assist with online enrollment as needed during the Open lab sessions below or by appointment. Sessions will be held in **Prairie Pavilion 2, Cottonwood/Red Oak meeting room, 2nd floor, near Human Resources**.

Monday, **Nov. 8** ..... 7 – 11 am
Wednesday, **Nov. 10** ..... 1 – 4 pm ***Bonutti Clinic***
Thursday, **Nov 11** ..... 12:30 – 3:30 pm
Wednesday, **Nov. 17** ..... 7:30 – 11:30 am
Friday, **Nov. 19** ..... 10 am – 2 pm

Introduction

One of the most important things we can do as your employer is to connect with you, professionally, and as importantly, personally. We know it is imperative to your wellbeing and that of your family's that you have access to meaningful benefits to help keep you healthy and financially secure. We have worked with our vendors to provide benefits that will give you a sense of peace.

Inside this booklet you'll find a flexible benefit plan that allows you to choose the plans that best fit your needs. It is only a brief overview. If you have any questions or need additional information, you may contact:

Sarah Bush Lincoln Human Resources
1004 Health Center Drive
Mattoon, IL 61938
Phone 217-258-2502
Toll Free 877-794-5627
Fax 217-258-4117

Benefit Plan

A flexible benefit plan is designed to give participants the opportunity to select among various taxable and nontaxable benefits in order to receive tax savings. It allows the employee to select benefit options that best meet his/her needs.

The Sarah Bush Lincoln flexible benefit plan contains the following qualified benefit options:

- employer-sponsored group health, dental and vision benefits
- flexible spending account (FSA)
- group term-life insurance
- group accident insurance
- long-term disability insurance
- short-term disability insurance
- critical illness insurance

Benefit coverage ceases at the end of the month in which the employee terminates employment or changes to a non-benefit eligible status.

TAX ADVANTAGES
The flexible benefit plan takes advantage of Section 125 of the Internal Revenue Code to allow you to pay for many of your optional benefits with pre-tax dollars. Pre-tax dollars are exempt from federal and state income taxes and Social Security taxes. Paying for optional benefits with pre-tax dollars saves most employees between 25 to 40 percent on their share of benefit costs.

ELIGIBILITY
All full-time and part-time employees of Sarah Bush Lincoln are eligible to participate in the flexible benefit plan. Spouses and other dependents of the employee may also benefit from the plan. Covered dependents are defined on page 20.

MAKING YOUR BENEFIT SELECTIONS
The Plan enables you to customize your benefits to your individual and family needs. We recommend you do the following to take full advantage of the Plan:

- Carefully review the Benefits booklet.
- Review the benefits available through your working spouse's employer (if applicable).
- Review your family needs and make your benefit decisions.
- Complete online benefit enrollment by the due date.

ROLES AND RESPONSIBILITIES
We all have a responsibility to help control costs and maintain the competitive benefits we enjoy. It requires everyone taking a more active role in their healthcare by being wise consumers.

Are you a wise healthcare consumer? Do you:

- Take care of yourself by exercising and eating right?
- Live a nicotine free lifestyle?
- Access Sarah Bush Lincoln or Consociate Health website to assess minor illnesses and injuries?
- Ask yourself if you would purchase the care if it were 100 percent your money?
- Participate in wellness programs at Sarah Bush Lincoln?

Your specific rights to benefits under each Plan are governed solely by the official Plan Documents and not the information in this manual. If there is any discrepancy between the Plans as described in this material and the Plans as described in the official Plan Documents, the language of the Plan Documents shall govern. Sarah Bush Lincoln reserves the right to revise, modify or terminate the Plans at any time.

ENROLLMENT GUIDELINES
Employees are eligible for benefits the first of the month following 30 days of employment. Initial enrollment must be completed within 14 days of hire or status change date and those benefit elections will remain in effect for the remainder of the plan year. If a new employee does not elect coverage as a new hire, he or she must wait until the next plan enrollment date – unless he or she experiences a HIPAA-qualifying event or a change in employment status. Documentation of qualifying event is required.

HIPAA QUALIFYING EVENTS

Mid-year changes only can be made in the case of the following:

- Change in marital status
- Change in number of dependents
- Change in employment which results in a gain or loss of eligibility for coverage
- Change in dependent eligibility due to plan requirements (definition of dependents, age limits, etc.)
- Judgments, decrees or orders (legal documentation required)
- Entitlement to Medicare or Medicaid

SECTION 125, CHANGE IN FAMILY STATUS

You must contact Human Resources within 30 days of the HIPAA-qualifying event or a "change in family status" in order to make a change in your benefit elections. Employees who experience a qualifying event during the course of the plan year must provide documentation of the event in order to revise benefit elections. If you do not request a change in your benefit elections within 30 days of the status change event, you will not be eligible to make a change or add or delete dependents until the next plan enrollment.

Any change in benefit elections must be consistent with the change in status. If you have questions relating to status change elections, please contact Human Resources.

Insurance Rates

PER PAY PERIOD CONTRIBUTIONS

– Full-time regularly schedule for 70 hrs. per pay period.
– Part-time regularly schedule for 40 hrs. per pay period.

	Health		Dental	Vision
FULL-TIME employees	*Standard Premium*	*Nicotine Free Premium*		
Individual	$90.24	$72.20	$8.52	$1.58
Employee & Child(ren)	$181.78	$145.42	$12.78	$2.36
Employee & Spouse	$210.27	$168.22	$14.91	$2.77
Employee & Family	$294.41	$235.53	$22.91	$4.27
PART-TIME employees				
Individual	$171.89	$137.52	$10.41	$1.93
Employee & Child(ren)	$348.09	$278.47	$15.62	$2.89
Employee & Spouse	$397.08	$317.66	$18.22	$3.38
Employee & Family	$562.19	$449.75	$28.00	$5.22

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out-of-pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider and will fall under the applicable plan Tier.
    b. The Tier 2 Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as 50 miles from the Sarah Bush Lincoln Health Center in Mattoon, IL and is measured from zip code to zip code.
    c. In the event services are not available from a Network Provider (Tier SBL, Tier 1 or Tier 2), then charges of a Non-Network Provider may be paid as though the services were provided by a Tier 2 Provider.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously–given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance

billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records. Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Transition of Care. If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Precertification Requirements

As soon as you know you will be having the service, or as soon as possible after receiving an emergency service*:

1. CAll AIMM at 877-217-7695 between the hours of 9 am and 5 pm Eastern Time (or leave a message on the 24/7 confidential voice mail).
2. Provide the name and date of birth of the patient.
3. Provide the name, group number, id number, address and phone number of the policy holder.
4. Provide the name and phone number of the facility where the services will be performed.
5. Provide the name and phone number of the doctor ordering the service.
6. Give a brief explanation to the RN of what service is being done and why.
7. Write down the reference number that the RN gives to you and present it when you go for the services.

Precertification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice.

Please contact AIMM at **1-877-217-7695** for all preauthorization items. AIMM contact information and preauthorization listing will also be included on your ID card.

Calendar Year Maximum Benefits for: PPO Plan Sarah Bush Lincoln Health Center				
All Essential Health Benefits	Unlimited			
	Tier SBL: In-Network Sarah Bush Lincoln Health Center	**Tier 1: In-Network Partner Vendors**	**Tier 2: In-Network HealthLink OA III**	**Tier 3: Out-of-Network Providers**
Definition	**SBL– owned/billed providers & facilities Hospital based providers**	**Previously in SBL Tier 1**	**HealthLink (Local) PHCS (National) Oral Surgeons**	
Providers	**SBL SBLFCH Billed under SBL tax ID Anesthesia services related to SBL visit**	**Family Care Associates Effingham Surgical Partners, LLC, Barnes Jewish facilities Wash U physicians Advanced Ophthalmology Dermatology & Mohs Surgery Institute**		
Please Note[1]	**All Services with the ability to be performed at Sarah Bush Lincoln will be required to be performed at SBL, SBLFCH, Effingham Surgical Partners, LLC, or Family Care Associates. If services are not performed at one of those locations, then the claim will be treated as Out-of-Network. Please contact Consociate or AIMM for approval to seek services outside of the SBL, SBLFCH, Effingham Surgical Partners, LLC, or Family Care Associates Facilities.**			
Deductible				
Individual	$600	$1,200	$2,500	$4,000
Family	$1,200	$2,400	$5,000	$8,000
Maximum Out-of-Pocket (includes Deductibles, Co-Insurance, Co-Payments, and Prescription Drug Co-Payments)				
Individual	$1,500	$2,500	$7,500	$15,000
Family	$3,000	$5,000	$15,000	$30,000
Coinsurance Level (unless otherwise specified)				
Individual and Family	100%	100%	75%	50%

All Deductible and Out of Pocket Tiers comingle with each other.

The following table identifies what does and does not apply toward the In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	**Applies to the In-Network Out-of-Pocket Maximum?**	**Applies to the Out-of-Network Out-of-Pocket Maximum?**
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments, **even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum**	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

[1]This note does not apply to individuals residing outside a 50-mile radius from SBL. The applicable benefits under each Tier will apply.

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met					
Allergy Services					
Office Visit	Primary Care: $25 copay Specialist: $40 copay	Primary Care: $25 copay Specialist: $40 copay	75%	50%	
Injections	100%	100%	75%	50%	
Serum	100%	100%	75%	50%	
Ground Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket
Air Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket. Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828
Ambulatory Surgical Center	$250 copay	$250 copay	75%	50%	Preauthorization is required for outpatient surgeries
Anesthesia	100%	100%	75%	50%	
Bariatric Surgery	Not Available	$250 copay	75%	50%	Preauthorization required
Birthing Center	Not Available	Not Available	75%	50%	Preauthorization required for some maternity stays
Blood & Plasma	100%	100%	75%	50%	
Cardiac Rehabilitation	100%	100%	75%	50%	Preauthorization required
Chiropractic Care	Not Available	100%	75%	50%	Limited to 20 visits per calendar year
Clinical Trials (Routine Patient Costs)	100%	100%	75%	50%	Preauthorization required
Cochlear Implants	Not Available	100%	75%	50%	
Dialysis	Not Available	100%	75%	50%	Preauthorization required
Durable Medical Equipment	100%	100%	75%	50%	Preauthorization required for equipment over $500
Gender Reassignment Surgery	Not Available	$250 copay	75%	50%	Preauthorization is required
Glaucoma, Cataract Surgery and Lenses (one set)	$250 copay	$250 copay	75%	50%	Preauthorization required
Hearing Aids	**Not Covered**				
Home Health Care	100%	100%	75%	50%	Preauthorization required.
Hospice					
Inpatient	$250 copay per admission	$250 copay per admission	75%	50%	Preauthorization required
Outpatient	100%	100%	75%	50%	
Family Bereavement Counseling	100%	100%	75%	50%	Limit of 6 visits
Hospital					
Inpatient Treatment	$250 copay per admission	$250 copay per admission	75%	50%	Preauthorization required
Outpatient Treatment	100%	100%	75%	50%	
Infertility Testing and Treatment	100%	100%	75%	50%	Preauthorization required. Lifetime Max of 6 attempts
Injections	100%	100%	75%	50%	Preauthorization required
Mastectomy Bra	100%	100%	75%	50%	1 per occurrence
Newborn Care	100%	100%	75%	50%	
Outpatient Diagnostic X-Ray and Lab	100%	100%	75%	50%	Preauthorization required for all high-tech imaging
Outpatient Emergency Services (includes all services performed in Emergency Room)	$300 copay then covered 100%	$300 copay then covered 100%	$300 copay then covered 100%	$300 copay then covered 100%	If admitted, $300 copay is waived. Preauthorization within 48 hours

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met					
Physician Services					
Primary Care Office Visits (includes OB/Gyn)	$25 copay	$25 copay	75%	50%	
Specialist Office Visits	$40 copay	$40 copay	75%	50%	
Physician Outpatient	100%	100%	75%	50%	
Labs, X-Rays	100%	100%	75%	50%	
Imaging (CT/PET/MRI)	100%	100%	75%	50%	Preauthorization required
Pregnancy Services					
Routine Prenatal and Postnatal Services	Office Visit: $25 copay Other Services: 100%	100%	75%	50%	Preauthorization required for some maternity hospital stays. Covered for Dependent Daughter
Non-Routine Prenatal Services, Delivery and all Inpatient Care	100%	100%	75%	50%	
Breast Pump	100% Deductible waived	100% Deductible waived	100% Deductible waived	Not covered	Limited to 1 per pregnancy
Pre-natal screening as defined under Women's Preventative Services of the Patient Protection and Affordable Care Act of 2010	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Preventative Care – Adult and Child					
Routine Physical Exam, including school and sport physicals for children	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Mammograms, including 3D	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Medically necessary Mammograms also payable the same as preventative Mammograms, and the ACA age limits do not apply.
Pap Smears	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Annual Hearing Exam	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Routine Digital Rectal Exams/Prostate Specific Antigen Test	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Colorectal Cancer Screens	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Including Cologuard
Outpatient Gastric Scopes	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Includes routine and medically necessary Colonoscopy, Sigmoidoscopy, Endoscopy, etc. (Includes scopes with polyp removal). The ACA age limits do not apply.
Routine Immunizations	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Private Duty Nursing	Not Available	75%	75%	50%	Limited to 70 visits per calendar year
Prosthetics, Orthotics, Supplies, Surgical Dressings	100%	100%	75%	50%	Limited to 2 foot orthotic devices or 1 pair of foot orthotic devices per calendar year (not limited to diabetes only)

SUMMARY OF HEALTH BENEFITS

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met					
Psychiatric Services					
Residential Treatment	Not Available	100%	75%	50%	Preauthorization required
Inpatient Treatment	$250 copay per admission	100%	75%	50%	
Partial Day Program	Not Available	100%	75%	50%	
Office Visits/Therapy	$25 copay	$25 copay	75%	50%	
Routine Foot Care	100%	100%	75%	50%	Covered for diabetics only
Second Surgical Opinions	100%	100%	75%	50%	
Skilled Nursing Facility	Not available	75%	75%	50%	Preauthorization required. Limit of 180 days per calendar year.
Sleep Disorders	100%	100%	75%	50%	
Substance Abuse					
Residential Treatment	Not Available	100%	75%	50%	Preauthorization required
Inpatient Treatment	Not Available	100%	75%	50%	
Partial Day Program	Not Available	100%	75%	50%	
Office Visits/Therapy	Not Available	$25 copay	75%	50%	
Outpatient Physician	Not Available	100%	75%	50%	
Surgery	$250 copay	$250 copay	75%	50%	Preauthorization required
Temporomandibular Joint (TMJ) Treatment	100%	100%	75%	50%	
Therapy					
ABA Therapy for Autism	100%	100%	75%	50%	Preauthorization is required. Therapy for autism does not count toward any other therapy limits.
Chemotherapy/Radiation	100%	100%	75%	50%	Preauthorization required
Occupational Therapy	$25 copay	$25 copay	75%	50%	Preauthorization required. Limited to 60 visits per therapy type per calendar year. Limit not applicable for Autism treatment.
Physical Therapy	$25 copay	$25 copay	75%	50%	
Speech Therapy	$25 copay	$25 copay	75%	50%	
Respiratory Therapy	100%	100%	75%	50%	
Vision Therapy	100%	100%	75%	50%	Limited to treatment of Autism
Transplants					
Recipient Expenses	Not Available	$250 copay	75%	50%	Preauthorization required. Centers of Excellence must be utilized.
Donor Expenses	Not available	$250 copay	75%	50%	Travel & Lodging benefit available when traveling more than 50 miles to where transplant is performed: (1) Lodging limited to $50/day; (2) Travel & Lodging combined limited to $10,000 maximum per transplant
Urgent Care[1]	Not Available	$25 copay	75%	50%	
Walk-In Clinics[1]	$25 copay	$25 copay	75%	50%	
Wigs	100%	100%	75%	50%	Following chemotherapy, radiation, burns or surgery, and diagnosis of alopecia. Limit of $300 per calendar year.
All Other Covered Services	100%	100%	75%	50%	

Preauthorization is required for all hospitalizations*/observations*, transplant services (including evaluations), Inpatient rehabilitations stays, substance abuse treatment (inpatient, residential and partial day program), mental health* (inpatient, residential and partial day programs), skilled nursing, home health care*, hospice*, PET*/SPECT*/MRI* and CT* Scans, Chemotherapy* and Radiation*, Therapy Services including Physical*, Speech*, Occupational*, and Cardiac Therapy*, Durable Medical Equipment over $500/Claim, and Pre-natal*/Maternity Care*. Please contact AIMM at 1-877-217-7695 for all Preauthorization items. AIMM contact information and preauthorization listing will also be included on your ID card.

*No pre-cert required at Tier SBL. Exceptions include: Outpatient Surgery and Durable Medical Equipment costing over $500/claim.

[1]This note does not apply to individuals residing outside a 50-mile radius from SBL. The applicable benefits under each Tier will apply.

Prescription Drug Benefits – PPO Plan

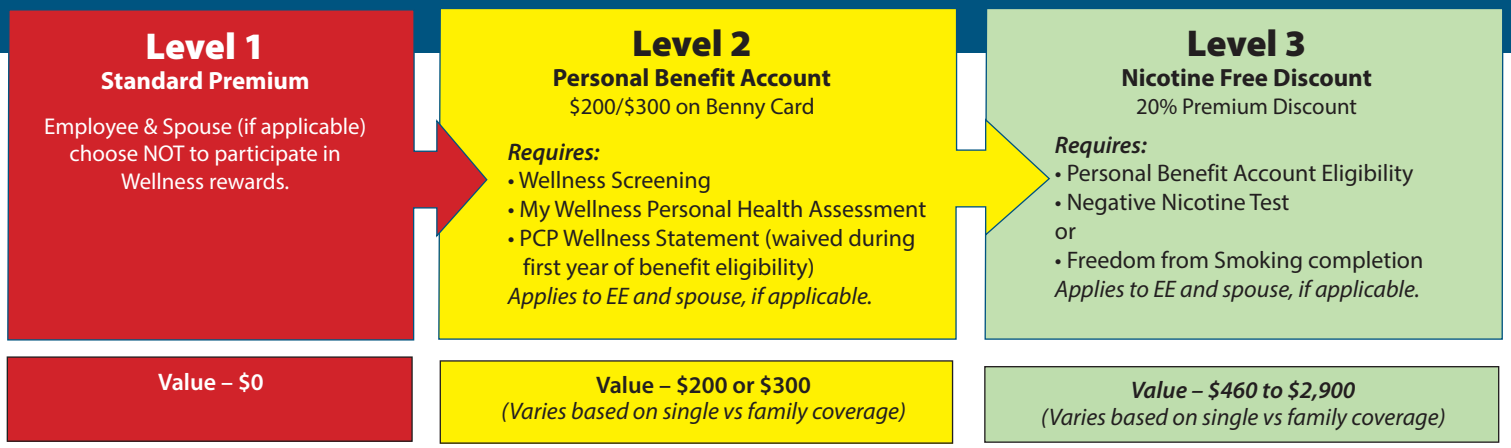
For Prescriptions filled through the Prairie Medical Center Pharmacy, the maximum individual and/or family out-of-pocket expenses will be reached at $2,500 Individual/$5,000 Family. This is combined with medical.

When prescriptions are filled outside the Prairie Medical Center Pharmacy and the individual and/or family out-of-pocket expenses reach the Tier 2 out-of-pocket maximum ($7,500 Individual / $15,000 Family), the Plan will pay 100% of the Allowable Expense for the remainder of the Calendar Year. No family member will be charged more than the individual out-of-pocket maximum.

Copays for prescriptions filled at Prairie Medical Center will not apply after the Tier 1 out-of-pocket maximum has been reached. All other prescription copays will continue until the Tier 2 out-of-pocket maximum has been reached.

Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
	Retail Pharmacy Option: Covers up to 30-day supply		
Copayment per prescription or refill, for generic	$10	$15	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$35	$40	
Copayment per prescription or refill, for non-formulary name brands	$60	$70	
Preventive Medications			
When purchased at Prairie Medical Center Pharmacy, medications on the Standard Plus Preventive Medications List are covered at a $0 copay for generics and diabetic medications and supplies. Brand name drugs will be subject to applicable copays.			
Specialty Drugs: Limited to 30- day supply			
Copayment per prescription or refill	50%, $200 Maximum		Must be filled through Prairie Medical Center Pharmacy. See Prescription Drug Benefits section.
Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
	Retail Pharmacy Option: Covers 31 to 60-day supply		
Copayment per prescription or refill, for generic	$20	$30	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$70	$80	
Copayment per prescription or refill, for non-formulary name brands	$120	$140	
Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
	Retail Pharmacy Option: Covers 61 to 90-day supply		
Copayment per prescription or refill, for generic	$30	$45	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$150	$120	
Copayment per prescription or refill, for non-formulary name brands	$180	$210	

2022 Health Plan Wellness Rewards



*For more detailed information, check the MyWellness portal, the employee benefit information tab on the SBL intranet or contact Human Resources **217-258-2501**.*

PERSONAL BENEFIT ACCOUNT (HRA)

The Personal Benefit Account (Health Reimbursement Account-HRA) is a consumer-directed health plan that encourages employees to take an active role in improving their health and managing their healthcare expenses. All employees enrolled in the SBL Health Plan are eligible for participation in the Personal Benefit Account. SBL will contribute to the employee's account based on employee and spouse (if applicable) participation in the following:

- Employee Wellness Screening
- PCP Wellness Statement

SBL Contribution to Personal Benefit Account

- $200 Employee
- $100 Additional for Spouse (if applicable)
- (Employees enrolled in EE & Child coverage level will automatically earn the additional $300 for employee participation.)

Contributions to the Personal Benefit Account are based solely on participation, not on health status (nicotine use, BMI, etc.).

Funds contributed to the Personal Benefit Account will be loaded to the Benny Card (a debit card) and may be used to pay for plan deductible and other out-of-pocket expenses related to health, dental or vision care. Eligible expenses mirror those for the Flexible Spending Account (FSA).

The Benny Card will hold the balance for the Personal Benefit Account in addition to any Flexible Spending Account (FSA) contributions the employee may elect. When using the Benny Card for covered expenses, deductions will be made from the Flexible Spending Account (FSA) before the Personal Benefit Account.

The Personal Benefit Account (Health Reimbursement Account-HRA) only allows employer contributions. The account does not permit additional employee contributions.

Any remaining balance in the Personal Benefit Account (HRA) may be carried over to the next plan year. Any remaining balance at the time an employee ceases to be a Health Plan participant is forfeited.

HEALTH PLAN PREMIUM DISCOUNT FOR NON-NICOTINE USERS

Living a nocotine-free lifestyle is not only good for your health; it also saves money on benefits costs, both for you and for SBL. In a continuing effort to encourage overall good health, a 20 percent discount is available for nicotine-free members.

To qualify for the discount, you and your spouse (if covered on the plan) must meet the qualifications for the Personal Benefit Account ***AND*** test negative for nicotine during your Wellness Screen.

If you are a new enrollee in the health plan, you and your spouse (if covered) must complete the Wellness screening by the 10th day of your benefit eligible month. Please call Employee Wellness at **217-258-2140** to schedule your appointment.

CURRENT NICOTINE USERS

Eligibility for the Nicotine-Free Premium is available to current tobacco users who participate in and complete the SBL Smoking Cessation program. Upon receipt of documentation that the employee (and/or spouse) has completed the program, the employee will be enrolled in the discounted premium level.

VISION BENEFITS

The following summary explains the SBL Vision Plan coverage. Claim forms can be found on the SBL intranet.

As a participant you and your dependent (if you elect family coverage) may receive the following vision benefits from any vision provider:

Examination.....Every 12 months
Glasses or
Contact Lenses.....1 pair every other calendar year

Contact lenses are in lieu of prescription lenses. You can select either, but not both prescription lenses and contact lenses. The benefit amount paid by the Vision Plan includes:

Examination.....$40
Glasses/ Contact Lenses.....$200

DENTAL BENEFITS

The following is a summary of the Sarah Bush Lincoln Dental Plan outlining the services covered. Claim forms can be found on the Sarah Bush Lincoln intranet.

Annual Dental Maximum $1,200 according to the following schedule of benefits.

Annual Deductible for Basic and Major Services

Individual..... $50
Family..... $150

Preventive Services

Covered up to 100 percent based on reasonable and customary changes – no deductible

- Routine exams & cleanings semi-annually
- Topical fluoride treatments for children up to age 16 annually
- Diagnostic X-rays semi-annually
- Full-mouth X-rays once in any three years

Basic Services

Covered 80 percent – after deductible

- Space maintainers
- Silver alloy or composite resin fillings
- Surgical and non-surgical periodontics
- Root canal fillings and pulpal therapy
- Simple and surgical extractions
- Fissure sealment (children up to age 19)
- Oral surgery

Major Services

Covered 50 percent – after deductible

- Prosthetics (bridges and dentures)
- Inlays, onlays and crowns

Orthodontic Services

Covered 50 percent – no deductible
$1,200 Lifetime Maximum

WELLNESS RESOURCES

CENTER FOR HEALTHY LIVING

The Center for Healthy Living (CFHL) is available to all employees and spouses/partners and family members in the household ages 16 and older. It features a complete fitness facility with treadmills, stationary bicycles, hand weights, resistance weight machines and a variety of fitness classes. Personal trainers are available to help members set and reach fitness goals.

Membership Rates

Individual Fee..... $20/month
Family Fee..... $35/month
Utilization Incentive – Employees who visit the CFHL fitness center 12 times a month will receive $10 reimbursement payments for each month. Reimbursement is done on a quarterly basis and the fitness member must be an employee of SBL at the time of pay out.

MY WELLNESS WEBSITE

Watch for the new Wellness Portal through Virgin Pulse. The Virgin Pulse wellbeing program helps you live better and achieve your health goals with a fun and engaging experience that delivers powerful resources right to your fingertips. It is offered to all SBL employees and their covered spouses/partners.

Move through levels as you earn points for the healthy choices you make each day! Enrollment will begin in January 2022.
Client Resource Center:
https://resourcecenter.virginpulse.com/
Password: VirginPulseCRC!

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Sarah Bush Lincoln EAP staff of behavioral health professionals can help with a wide range of issues including:

- Family or marital conflict
- Divorce/stepfamily adjustments
- Grief recovery
- Stress management
- Workplace conflict
- Coping with health problems
- Depression and other emotional illness
- Adjustments in life
- Anger management
- Immediate or urgent issues
- Substance use problems
- ADHD counseling

How much will EAP services cost me?

– Your employer has paid for EAP services and offers them as a benefit to its employees and their families.

Will my family be covered?

– EAP services cover your family members who live in the same household as you. Please call the Sarah Bush Lincoln EAP office if you need clarification about coverage for family members.

How do I make an appointment?

– To arrange an appointment, call the Sarah Bush Lincoln EAP office at **217-258-4040**.

Additional EAP benefits are available through ACI Benefits including Work-Life Services available through a phone (or tablet) application, providing face-to-face counseling, legal and financial services and advice, grief counseling, identity theft services, and travel emergency assistance. http://rsli.acieap.com

SBL PROVIDED BENEFITS

LIFE INSURANCE

Full-time employees receive a standard life insurance benefit of two times your annual salary with a maximum benefit of $250,000. The benefit is provided at no cost to you and will be paid to your designated beneficiary in the event of your death. The amount of basic life and voluntary life insurance is reduced to 65 percent of the face value at the age of 65, 40 percent at age 70 and 20 percent at age 75.

ACCIDENTAL DEATH AND DISMEMBERMENT

Full-time employees are provided with an Accidental Death and Dismemberment benefit of two times their base salary with a maximum benefit of $250,000.

LONG-TERM DISABILITY

Sarah Bush Lincoln provides full-time employees with basic LTD coverage at no cost. If you become totally disabled, the basic LTD Plan will pay 60 percent of your base earnings up to a maximum benefit of $6,000 per month. Payments will begin after you have been totally disabled for 90 days.

VOLUNTARY BENEFITS

VOLUNTARY TERM LIFE INSURANCE

Full-time and part-time employees may choose up to $250,000 of Voluntary Term Life Insurance. The rates are based upon your age and will be displayed on the online enrollment site. Coverage up to $250,000 is guaranteed without Evidence of Insurability for new employees who enroll within 30 days of their eligibility date.

The additional life insurance you purchase through the Plan can be ported or converted, which means that even after your employment with Sarah Bush Lincoln, you may keep the group rate or convert your current policy to a non-term permanent life insurance policy without evidence of insurability as long as application is made within 30 days of termination of insurance.

SPOUSE LIFE INSURANCE

Spouse (civil union partner) Life Insurance may be purchased as an option in units of $10,000 not to exceed a maximum of $150,000. Coverage of up to $30,000 is guaranteed without Evidence of Insurability for spouses of new employees who enroll within 30 days of their eligibility date. The rates are based upon the employee's age as of the first day of the Plan Year (January 1). Like Voluntary Term Life, Spouse Life Insurance may also be ported or converted to a non-term permanent life insurance policy without evidence of insurability as long as application is made within 30 days of termination of insurance. Spouse Life Insurance benefit decreases at age 65 and is not available for those age 70 and above.

CHILD(REN) LIFE INSURANCE

Child(ren) Life Insurance is available as an optional benefit. You may purchase coverage on all your ***unmarried dependent children*** birth to 26 years for a single premium. This coverage offered is $10,000 and does not require evidence of insurability for children of new employees who enroll within 30 days of eligibility date. Coverage for disabled dependents may be restricted. Please contact Human Resources for details.

Employees must purchase Voluntary Term Life for themselves in order to purchase Spouse Life or Child(ren) Life Insurance. Spouse and child election cannot be greater than the employee's election.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT

The Plan also allows you to purchase Voluntary Accidental Death and Dismemberment (AD&D) Insurance for yourself, your spouse, civil union partner and your unmarried dependent children birth to 26 years.

SHORT-TERM DISABILITY (STD)

As a full-time or part-time employee, you have the opportunity to purchase STD coverage to protect your income.

With the STD plan, you are eligible for a weekly payment up to 60 percent of your base earnings. You also have the flexibility to choose between two coverage options.

- Coverage beginning after 14 days of disability
- Coverage beginning after 30 days of disability

A pre-exisiting clause applies to new plan enrollees. During the first six months of coverage, benefits will not be paid if the absence is related to any condition for which there was treatment during the three months immediately prior to

the coverage effective date. After six months in the plan, all eligible conditions are covered.

Please take your current TOP and Reserve Sick (RS) balance into consideration when electing this benefit.

This insurance covers employees who become disabled as a result of an injury or sickness that is not work related. It replaces a part of the income the employee would have earned had they been able to continue working.

CRITICAL ILLNESS INSURANCE - *Enhanced!*
Critical Illness Insurance through Reliance Standard protects your family and your assets. No one saves to get sick, which is why being diagnosed with a covered condition can be especially draining, both emotionally and financially. The policy provides a lump sum cash benefit in the event you or an insured loved one is diagnosed with a covered condition such as cancer, heart attack, or stroke. It can help provide financial protection so you can focus on getting better. And now, this benefit also includes COVID-19 protection! As well, every year that you complete a qualified health screening you are eligible for a $50 Wellness Benefit.

During this open enrollment period only, you can elect up to $30,000 in coverage for yourself without answering medical questions!

ACCIDENT INSURANCE - *NEW!*
Accident Insurance from Reliance Standard can help cover the out-of-pocket costs associated with an accident that takes place on or off the job by paying you a benefit for events such as ambulance transportation, ER visits, doctor visits and follow-up treatment, fractures and dislocations, burns, surgery, medical equipment, torn cartilage, and more.

The policy does not coordinate with any other coverage, so you can receive benefits on top of what your medical plan provides. You can use the money as you see fit, whether to pay for expenses associated with your accident, like an ER copay, or to pay for childcare so you can get to the doctor for a follow-up visit. And every year that you complete a qualified health screening you are eligible for a $50 Wellness Benefit.

HOSPITAL INDEMNITY INSURANCE - *NEW!*
An unexpected hospital stay can put a strain on your budget. Hospital Indemnity Insurance through Reliance Standard is designed to provide you with financial protection by paying you a benefit for each day that you spend in hospital confinement as well as a hospital admission benefit.

Since the plan pays the benefit directly to you, in addition to what your medical plan covers, you can use the benefit however you want. Use it to pay for out-of-pocket expenses and extra bills relating to your hospitalization, or for other expenses, like buying groceries or paying for childcare. And every year that you complete a qualified health screening you are eligible for a $50 Wellness Benefit.

UNIVERSAL LIFE INSURANCE WITH LIVING BENEFITS - *NEW!*
Transamerica offers you additional financial protection you may need. The unique feature of Universal Life Insurance is that you build cash value on a tax-deferred basis (until withdrawn) which may allow your premiums to remain level throughout the life of the contract. Universal Life Insurance offers flexibility to adjust your benefit amount up or down depending on your current insurance needs. This coverage also offers you "living benefits" should you need Long Term Care after becoming chronically ill and confined to a nursing or assisted living facility, or if you need to receive home health or adult day care.
During this open enrollment period only, you have the opportunity to elect up to $150,000 in coverage for yourself without answering medical questions!

PERKSPOT - *NEW!*
EMPLOYEE DISCOUNT PROGRAM
SBL is happy to offer you PerkSpot, a one-stop-shop for exclusive discounts at many of your favorite national and local merchants! PerkSpot is completely free, and optimized for use on any device: desktops, tablets, and phones.

Getting Started: Sign up or log in at sbl.perkspot.com. Follow the simple on-screen instructions to make an account with your personal or work email.

Start Saving: Enjoy access to thousands of discounts in dozens of categories, updated daily. Take advantage of online offers from popular national retailers, and discover discounts in your neighborhood with PerkSpot's streamlined Local Map. Filter your map results by categories like restaurants, health & fitness, retail, and more!

Remember: Don't see the retailer or product you want? You can always request a merchant through your PerkSpot account, and our negotiating experts will work to get it for you. Keep an eye out for new featured discounts in PerkSpot's weekly email!

FLEXIBLE SPENDING ACCOUNT (HSA)

The flexible benefit plan offers you a choice to participate in comprehensive health, dental and vision plans. However, as with any plan, there are some items that are not covered or are only partially covered. The FSA is designed to let you take advantage of current tax laws and pay for these out-of-pocket expenses with pre-tax dollars. New elections must be made each calendar year.

How It Works

The FSA allows you to deposit up to $2,750 annually into an account, on a pre-tax basis, to pay for medical expenses not covered by another plan. Your FSA can be used to reimburse you for expenses incurred by you or your dependents regardless of whether you participate in any of Sarah Bush Lincoln's health, dental or vision plans.
There are two ways to access funds in your FSA account.

1. Flexible Spending Cards

Employees participating in the Flexible Spending accounts will receive a Benny card. This spending card automates the process of paying for eligible pre-tax account expenses. The card can be used at eligible locations where MasterCard and Visa are accepted, from physician and dental offices to pharmacies and vision service locations. Approved expenses are automatically deducted from the participant's pre-tax account. If not able to produce receipts to verify expense eligibility, the reimbursed amount will be taxable.

2. Submitted Request

Requests for reimbursement may be submitted along with a bill showing the date of service, type of service, provider name and the amount to:

Consociate
2828 N. Monroe
Decatur, IL 62526
1-800-798-2422
217-233-2281 (fax)
www.consociatefsa.com

Flexible Spending reimbursement forms can be found on the SBL intranet at human resources/employee benefits or at www.consociatefsa.com. A direct deposit option is also available for reimbursement checks.

Internal Revenue Service Plan Requirements

Because this account gives you a unique opportunity to reduce your taxes, certain Internal Revenue Service requirements apply:

- Expenses claimed for your account must be incurred during the Plan Year (January 1 – December 31).
- Money in excess of $550 not claimed for the Plan Year will be forfeited – sometimes called the "Use It or Lose It" Provision. You will have up to three months after the end of the Plan Year (March 31) to file claims for services incurred during that year.
- The amount you contribute to the account must remain the same all year unless you experience a "change in family status" and make an election change.
- You may not claim any expense reimbursed from this account as an itemized deduction on your tax return.

RETIREMENT PLAN 403(b)

Sarah Bush Lincoln provides a qualified defined contribution retirement plan for you.

Eligibility

Employee Contribution - All employees (FT, PT, per diem, PRN) may begin making contributions to the retirement plan from their date of hire. You may invest up to the 402(g) limits on either a pre-tax or post-tax (Roth) basis.

Employer Contribution - Participating employees become eligible for the employer match on January 1 or July 1 following completion of one year of service, 1,000 hours, and attainment of age 21. In order to retain the match, you must work at least 1,000 hours during the plan year. The match is equal to 50 percent of your contribution, not to exceed 4 percent.

Auto-Enrollment Feature

New employees will be subject to the auto-enrollment feature of the 403(b) retirement plan. Employees will be enrolled in the plan at 4 percent deferral rate effective 30 days following employment. Employees may enroll online to indicate a different contribution amount and/or fund election or may elect not to participate in the plan.

Investments

You may choose to invest contributions into the retirement plan by selecting individual investment funds from the plan offerings. You may also choose from several target date portfolios which are actively managed by investment professionals who choose the investment proportions and adjust them over time for you.

Vesting

The vesting schedule defines your level of ownership of Sarah Bush Lincoln's contribution made on your behalf. You will always be 100 percent vested in the value of your contributions to the plan. You will be vested in the value of Sarah Bush Lincoln's contribution according to the following vesting schedule:

Vesting Schedule

Years of Service	% Vested
1	0
2	20
3	40
4	60
5	80
6	100

Retirement Contributions Chart		
YOUR CONTRIBUTION *If you contribute the following amount of pay:*	**SARAH BUSH LINCOLN CONTRIBUTION** *Then SBL will contribute the following amount:*	**TOTAL CONTRIBUTION**
1%	1/2%	1 1/2%
2%	1%	3%
3%	1 1/2%	4 1/2%
4%	2%	6%
8%	4%	12%
10%	4%	14%

Retirement Benefits
You may receive retirement benefits from the plan when you reach the normal retirement age of 65. You are also eligible to take an in-service distribution at age 59 and 1/2. Full details of the retirement plan may be found in the summary plan description.

Participants can enroll in the plan, monitor plan activity, make changes to their contributions/investments, update beneficiaries, and much more by logging in to the Fidelity website (www.netbenefits.com/sbl) or by calling Fidelity Retirement Service Center at **1-800-343-0860**.

TIME OFF PAID (TOP) Program

The purpose of the TOP program is to provide a flexible and equitable means for you to use paid time off from work for vacations, holidays, illnesses and unforeseen contingencies (i.e. injury, personal emergency, bad weather, etc.) All full-time and part-time employees accrue benefit (TOP) time based on length of continuous eligible service from last date of hire.

See an example below of how a new full-time employee may use their TOP time:

Vacation	10 days
Holidays	6 days
Sick	5 days
Personal	2 days
Total	**23 Days**

The TOP program, in which all of your earned credit for vacation, holidays and short-term "sick" time allowance accumulates, adds to your benefits package. You have the opportunity to use your TOP hours in the manner that best suits your personal needs with the approval of your manager/director.

Accrual of TOP hours for eligible employees begins immediately upon employment. Upon hire, eligible employees may use TOP hours for holidays, not to exceed accrued hours currently in their TOP account. You may accrue up to a maximum of 400 TOP hours. TOP accrual rates vary based on length of continuous eligible service from the last date of hire as shown in the chart below.

The following holidays are recognized by Sarah Bush Lincoln:

New Year's Day	Labor Day
Memorial Day	Thanksgiving Day
July 4th	Christmas Day

RESERVE SICK

The Reserve Sick time account provides protection from pay losses due to an employee's own hospitalization, long-term serious medical problems, outpatient surgery, oral surgery, invasive procedures, procedures requiring sedation and open or closed reduction of fractures. A physician note is required to access Reserve Sick.

A limited amount of time may apply for family illness. See Reserve Sick policy for more information.

All full-time and part-time employees accrue .02692 Reserve Sick hours per hour paid (to a maximum of 80 hours per pay period). The Reserve Sick account may accrue to a maximum of 600 hours. The 600-hour maximum will enable long-term employees to receive full pay during the 90-day waiting period that precedes eligibility for long-term disability payments.

TUITION ASSISTANCE

As a full-time or part-time employee who has successfully completed your trial period, you are eligible

TOP Hours Earned by Eligible Full-time and Part-time Employees			
Length of Eligible Services	**Per Hour Paid**	**Per Hour Paid 80 Hours**	**Per Average Year of Employment – 2,080 Hours Paid**
1 – 5 years	.08846	7.0768	184 hours (23 days)
5 – 9 years	.10769	8.6152	224 hours (28 days)
9 + years	.12692	10.1536	264 hours (33 days)

to receive tuition reimbursement for approved courses. Determination of course eligibility is the responsibility of your supervisor and the director of Employee and Organizational Development (EOD). Courses must be taken through an accredited school or recognized accredited program. The subject matter must be directly related to your current position or a position to which you may be logically promoted, or part of a related degree program. If you are planning on earning a degree, the degree plan must be approved by your supervisor before taking classes.

You should complete the tuition reimbursement request form available online found under the Human Resources tab on the SBL intranet and submit it to your supervisor for approval prior to registering for a course. If approved, your supervisor will forward the request to EOD for approval. Receipt of tuition assistance is also subject to yearly budget limitations. Employees may be eligible for tuition assistance loans from their healthcare association credit union. Full-time employees are eligible for up to $4,000 in tuition reimbursement a year, while part-time employees are eligible for up to $2,000 a year. Reimbursement will be contingent upon your continued employment for a minimum of 12 months beyond the successful completion of the course. If you terminate employment within the 12-month period, you will be required to pay back a prorated amount of the tuition assistance and any amount not paid will be deducted from your final paycheck.

Financial assistance from other sources will be taken into consideration when determining the reimbursement amount. The intent of Sarah Bush Lincoln is to reimburse you for qualified tuition costs, but not to have the total reimbursement received by you from all sources exceed the cost of tuition.

You must achieve a grade of "C" or better for undergraduate work and a "B" or better for graduate work to qualify for reimbursement. Courses taken "pass/fail" must receive a "pass" grade to qualify for reimbursement.

FARMERS INSURANCE

AUTO, HOMEOWNERS AND RENTERS INSURANCE
METPAY offers employees a convenient, cost-effective way to insure their auto, home and personal property. With the payroll deduction option, employees are able to spread their premiums out over the policy term. If you would like additional information about these services, please call:

Farmers Insurance
1-800-438-6381

COBRA

Employee's Rights to Continue Group Health Coverage

YOU AND YOUR SPOUSE AND DEPENDENTS SHOULD READ THIS INFORMATION, REGARDLESS OF YOUR CURRENT EMPLOYMENT STATUS WITH SARAH BUSH LINCOLN.

If you are an employee of SBL, covered by a Group Health Plan offered by SBL, you have the right to choose continuation coverage at group rates if you become ineligible for group health coverage because of a voluntary resignation, reduction in hours or termination of employment (for reasons other than gross misconduct on your part).

Consociate is the administrator of COBRA for SBL. COBRA notification, enrollment, payments, changes in coverage and terminations will be processed by Consociate COBRA services.

If you are a spouse of an employee of SBL covered by a Group Health Plan offered by SBL, you have the right to choose continuation coverage for yourself if you become ineligible for group health coverage, under the plan for the following reasons:

1. The death of your spouse;
2. A voluntary resignation or termination of your spouses' employment (for reasons other than gross misconduct) or for reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage under SBL is lost for any of the following reasons:

1. The death of a parent;
2. A voluntary resignation or termination of parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with SBL;
3. Parent's divorce or legal separation;
4. The dependent child ceases to be a "dependent child" under the plan.

There may be other coverage options for you and your family. You may be able to buy coverage through Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will

be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the US Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov.ebsa or call its toll-free number at **1-866-444-3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Your Responsibilities
Under the law, you and your family member(s) have the responsibility to inform the benefits specialist of a divorce, legal separation, or child losing dependent status under the plan within 60 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. Sarah Bush Lincoln has the responsibility of notifying the Plan Administrator of the employee's death, termination, reduction in hours in employment or Medicare entitlement. Similar rights may apply to certain retirees, your spouse, and dependent children if Sarah Bush Lincoln commences a bankruptcy proceeding and these individuals lose coverage.

When the Human Resource department is notified that one of these events has happened, the COBRA Administrator will, in turn, notify you generally within 14 days after notice of a qualifying event has occurred that you have the right to choose continuation coverage. You have at least 60 days from the date you would lose coverage because of one of the events described above, or the date of notice of your election notice is sent to you, whichever is later, to inform the Benefits Specialist that you want continuation coverage. If you do not choose continuation coverage, your group health will end.

If you choose continuation coverage, Sarah Bush Lincoln will give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated non-COBRA beneficiaries or family members. You will be afforded the opportunity to maintain continuation coverage up to 36 months unless you lost group health coverage because of termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. Additional information on notification requirements can be found on the SBL intranet/employee benefits.

DISABILITY EXTENSION

If an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan is generally required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. The individual must be disabled at the time of termination of employment or reduction in hours of employment. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes changes to current law to provide that, beginning January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes it clear that, if the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension.

The affected individual must notify WageWork within 30 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond three years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

Definition of Qualified Beneficiary
Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse, and dependent children of a covered employee and, in certain circumstances, the covered employee. In order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as termination of employment, or a divorce from, or the death of, the covered employee). HIPAA changes this requirement so that a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

TERMINATION OF CONTINUATION COVERAGE

Your continuation coverage may be terminated for any of the following five reasons;
1. Sarah Bush Lincoln no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;

3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting condition you or your covered dependents may have.
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

DURATION OF COBRA CONTINUATION

Under the COBRA rules there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. If the other group health plan limits or excludes coverage for any pre-existing condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA limits the circumstances in which plans can apply exclusions for the pre-existing condition. HIPAA makes a coordinating change to the COBRA rules so that if a group health plan limits or excludes benefits for preexisting conditions, but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing COBRA continuation coverage can stop making the COBRA continuation coverage available. The HIPAA rules limiting the applicability of exclusions for pre-existing conditions become effective in plan years beginning on or after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements.)

You do not have to show that you are insurable to choose continuation coverage. However, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If you have changed marital status, or you or your spouse have changed addresses, please notify the SBL Benefits Specialist. If you have any questions, please contact:

SBL Human Resources Department,
1004 Health Center Drive,
Mattoon, IL 61938.
217-258-2502

Terms to Understand

Premium
The premium is a set amount that is deducted from your paycheck per pay to retain healthcare coverage. The price is the same, regardless of the service.

Deductible
The deductible is what you pay each year for covered expenses before the plan begins to make payments. Deductible amount varies according to where you receive your care.

Co-Payments
After meeting your deductible, a co-payment is a set dollar amount you are required to pay each time you receive certain Covered Health Services.

Plan Coverage
After meeting your deductible and co-pay if applicable, the Plan Coverage takes effect. Plan Coverage is the percentage of cost the plan pays for services, and applies to all covered expenses.

Maximum Out of Pocket
The Maximum Out-of-Pocket provision protects you financially by limiting the amount you pay for covered medical expenses in a calendar year. Once your expenses (including the deductible, co-pays and co-insurance you pay) reach the maximum out-of-pocket, the plan picks up 100 percent of eligible expenses for the rest of the year. This provision does not apply to charges above the usual and customary amounts.

Flexible Benefit Plan
This type of plan is sometimes called a cafeteria plan or section 125 plan. It provides you with valuable benefits by offering a menu of benefit choices and allowing you to select the options that are best for you and your family.

Pre-tax Dollars
Dollars that you use to buy optional benefits that are exempt from payroll taxes. They are deducted from your paycheck before taxes are calculated and are not included on your annual W-2 Form as taxable wages.

Plan Year - January 1 through December 31
You must enroll within the first 14 days of your hire date and the benefits selected can only be altered mid-year if you have a "change in family status," or experience a "HIPAA-qualified event."

T***ermination of Coverage***
Coverage under the plan terminates at the end of the month in which you terminate employment or as otherwise noted in the benefit plan documents.

Covered Dependent
An individual, as described below, who has met the eligibility requirements of the Plan and for whom coverage is in effect.

For health, dental and vision plans, qualified dependents include your legally married spouse or civil union partner and children under age 26 regardless of student status. "Children" include: your natural children; stepchildren; children for whom you are the legal guardian; foster children; legally adopted children; and children for whom you are the proposed adoptive parent and who are dependent upon you during the waiting period prior to the adoption becoming final. Dependent coverage may be continued following legal separation or divorce of the parent should the court so decree. The Plan may require proof of dependency for any person claiming to be your dependent.

All employees adding a spouse or civil union partner after initial enrollment will be required to provide appropriate documentation (certificate of marriage or civil union).
An individual is not a qualified dependent if on active duty in the armed forces of any country or if covered under the Plan as an eligible employee. If both parents are eligible as employees, dependent children will be considered eligible dependents of only one employee.

A dependent who is incapable of self-sustaining employment and is dependent upon his or her parents or other care providers for lifetime care and supervision because of a handicapped condition which occurred before attainment of the age of 19 will continue to be covered under the Plan beyond the age limits above, provided the eligible employee remains covered and such dependent remains continuously incapacitated and dependent.

Full-time Employee
An employee who is regularly scheduled to work at least 70 hours in a normal (two-week) pay period.

Part-time Employee
An employee who is regularly scheduled to work at least 40 hours or more, but less than 70 hours in a normal (two-week) pay period.

ACA-Eligible Employee
An employee who is NOT in an SBL benefit-eligible status but who has been employed for at least 12 months and worked an average of 30 hours a week during the eligible period. ACA-eligible employees have the opportunity to enroll in the health plan. ACA-eligible employees will be notified by Human Resources if they are eligible to enroll

IMPORTANT YEAR-END REMINDERS FOR 2021

FLEXIBLE SPENDING ACCOUNT (FSA)

	BENNY CARD	PAPER CLAIM FORM	BALANCE
2021 Dates of Service *(Related deductible, copays and other eligible expenses)*	Eligible for use through December 31, 2021	Submit to Consociate January 1, 2022 through March 31, 2022	Remaining balance of up to $550 will be moved to 2021 plan on April 1, 2022
2022 Dates of Service *(Related deductible, copays and other eligible expenses)*	Use beginning January 1, 2022		

RETIREMENT PLAN INFORMATION

• Please refer to the www.IRS.gov for amount contribution limits.

• If you would like to enroll in the plan, increase your contribution amount, or change your investment election, please go to the Fidelity website. Changes submitted by January 4, 2022 will be reflected on the first paycheck in January.

• If you haven't already done so, please also access the Fidelity website to enter or update your beneficiaries.

• You may access the Fidelity website from the SBL intranet (Human Resources/Retirement Plan website) or at www.netbenefits.com/SBL. Fidelity Customer Service is available at 1-800-343-0860.

• Retirement Plan representatives are available for one-on-one appointments. Please call Human Resources at **217-258-2501** to schedule an appointment.

TOP SELL BACK DECLARATIONS FOR 2022

To sell back TOP hours at full value in 2022, employees must complete a sell back declaration form and submit it to payroll no later than December 31, 2021.

The "SBL Request for TOP Sellback – Prior Year Election" form is included in policy "SC011 Time Off Paid (TOP)." NOTE: By declaring in 2021 that you intend to sell back TOP hours in 2022, you can avoid the 15 percent IRS mandated penalty that is assessed for sell backs requested in the same year (sell backs requested in 2022 and paid in 2022). There are limitations on TOP sell back, which are outlined in the policy and on the declaration form. All requests submitted to Payroll before December 31, 2021 will be processed on the first regular payroll in June 2022.

W2 DISTRIBUTION

W2s will be printed and mailed to employee homes before January 31, 2022. Your W2 will be sent to the address in your Employee Space. Please access Employee Space/Edit Profile/ Personal Information to review or update your address.

Benefit Resources 2022

Benefit / Vendor	Phone/Hours/E-mail/Fax	Website
General Benefits Information		
Sarah Bush Lincoln Human Resources	217-258-2501 or 217-348-2501 Monday – Friday 7:30 am - 4:30 pm humanresources@sblhs.org	SBL Intranet – Human Resources/Employee Benefits
Medical Benefits		
Consociate Health Group Number – C100102	800-798-2422 Precertification-AIMM-877-217-7695	https://consociatehealth.com
Pharmacy Benefits		
Express Scripts-Rx Benefits RXBIN: 610014 RxGRP: RXBSABU	800-334-8134 e-mail-RxHelp@rxbenefits.com	www.express-scripts.com
Dental Benefits		
Consociate Group Number - C100102	800-798-2422	https://consociatehealth.com
Vision Benefits		
Consociate Group Number - C100102	800-798-2422 Fax – 217-233-7252	https://consociatehealth.com
Flexible Spending Accounts (FSA)/ Personal Benefit Account (PBA)		
Consociate Flexible Spending Reimbursements Benny Card Balances	800-798-2422 Fax – 217-233-2281	www.consociatefsa.com
Critical Illness Insurance/Accident/Hospital Indemnity		
Reliance Standard Policy#802139		ClaimsIntake@rsli.com www.RSLClaims.com
Life/Disability Insurance		
Reliance Standard To report a claim for Short Term Disability Policy#328435 Long Term Disability Policy#131394	1-855-775-2524	www.RSLClaims.com
Home and Auto Insurance		
Farmers Insurance	1-800-438-6381 Monday–Friday 8:00 am–6:00 pm EST	
Retirement Plan		
First Mid Illinois Bank and Trust Investment Consultation	888-518-7878 217-258-3344 retirement@firstmid.com	
Fidelity Customer Service Call Center	800-343-0860	www.netbenefits.com/sbl
Employee Wellness Program		
SBL Wellness	217-258-2140 or 217-348-2140	
Employee Assistance Program		
SBL Employee Assistance	217-258-4040 or 217-348-4040 866-567-2400 (24 hour line)	
Work-Life Services		
On-line Employee Assistance, Identity Theft, Legal & Financial Services, Travel Emergency	1-855-755-4357 ID Theft: 1-855-246-7347 Travel Emergency: 1-800-456-3893	http://rsli.acieap.com www.reliancestandard.com/walletarmor
Pharmacy Refill		
Prairie Medical Pharmacy	217-258-2411 or 217-348-2411	SBL Intranet – Prescription Refills

Notes

HOW TO ENROLL

New Employee Benefit Enrollment must be completed within two weeks (14 days) of hire date.

3 Easy Steps

1

GO TO

- the **SBL intranet** – click on the Benefit Enrollment link at the top of the page
  OR
- **https://www.benxpress.com/sblhs**

2

LOGIN

If you are logging on for the first time, your sign-in information will be:

- ***User ID*** **–** the first initial of your first name + last name *(This is NOT case sensitive)*
- ***Password*** **–** the last 6 digits of your Social Security Number

Here's and example:
Joe Sample, Social Security number 123-45-6789
User ID – jsample
Password – 456789

If you have changed your password in the past year and do not remember it, please use the "Trouble Logging In" button to reset your password.

3

GET STARTED

- Follow and read all Important Notices and Instructional Information.
- Click on "Hints" when you need guidance.
- Click the "Next" button to advance.
- Click on "Previous" to go back.
- Click on "Your Resources" for detailed summaries and information.

Important
You MUST click "SAVE" at the END of the enrollment or you will not be enrolled.

Enrollment Reminders

- Verify accuracy of dependent information.
  (Is the Social Security number correct? Is the dependent less than 26 years old? etc.)
- Verify beneficiaries.
- New enrollees – schedule wellness screen and complete PHA, if applicable, by December 10, 2021.
- Set 2021 Flexible Spending Account (FSA) election
- Complete and submit evidence of insurability, if applicable.

Questions? Give Human Resources a call at **217-258-2501**.