2025 BENEFITS GUIDE

Satanta District Hospital

BENEFITS OVERVIEW

Satanta District Hospital is proud to offer a comprehensive benefits package to eligible employees. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental and vision), and Satanta District Hospital provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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ELIGIBILITY

Employees

As an employee, you are eligible for benefits if you are regularly scheduled to work at least 24 hours per week. For new hires, elected benefits will begin on the first of the month after 1 month of employment.

Your Eligible Dependents

Eligible dependents are your legal spouse, children under age 26 or unmarried disabled dependents of any age. Documentation of dependent eligibility will be required.

ENROLLMENT

New Hire or Newly Eligible Employees

You have 30 days from your hire date or the date you became an eligible employee to make your benefit elections and complete your enrollment. If you do not submit your enrollment information by the deadline, you will only receive the employer-paid benefits. You will not be able to enroll in other plans or make changes until the next open enrollment (unless you experience a qualifying life event).

Open Enrollment

Some voluntary benefits are only available to elect during open enrollment. Any election made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Qualifying Life Event

The only other opportunity you have to make a change to benefit elections, outside of open enrollment, is if you experience a qualifying life event. You have 30 days from the date of the event to make changes to your benefits. Qualifying life events include:

- Marriage
- Divorce
- Birth or adoption
- Death of a spouse or dependent
- Change in your child's dependent status
- Change in your spouse's employment status
- Involuntary loss of other insurance coverage

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 34 - 37 for more details.

MEDICAL BENEFITS

Administered by Auxiant

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO PLAN - OPTION 1	PPO PLAN - OPTION 2	HDHP PLAN - OPTION 3
	In-Network	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited		Unlimited
Calendar Year Deductible	$1,500 single / $3,000 family	$2,500 single / $5,000 family	$5,000 single / $10,000 family
Calendar Year Out-of-Pocket Maximum	$6,600 single / $13,200 family		$6,600 single / $13,200 family
Coinsurance (after deductible)	20%		20%
DOCTOR'S OFFICE			
Primary Care Office Visit	$35 copay		20% Coinsurance
Specialist Office Visit	$70 copay		20% Coinsurance
Preventive Care (screening, immunization)	No Charge		No Charge
Diagnostic Test (x-ray, blood work)	20% Coinsurance		20% Coinsurance
Imaging (CT/PET scans, MRIs)	20% Coinsurance		20% Coinsurance
PRESCRIPTION DRUGS (30-Day supply)			
Retail—Generic Drugs	$15 Copay		Deductible then $15 Copay
Retail—Preferred Brand Drugs	$50 Copay		Deductible then $50 Copay
Retail—Non Preferred Brand Drugs	$75 Copay		Deductible then $75 Copay
Specialty Drugs	Limited to 30-day supply and must be obtained through Payer Matrix 877.305.6202 (Copay could be $150 or 20% coinsurance up to $250)		Limited to 30-day supply and must be obtained through Payer Matrix 877.305.6202 (Copay or Coinsurance may apply)
HOSPITAL SERVICES			
Emergency Room	20% Coinsurance		20% Coinsurance
Inpatient	20% Coinsurance		20% Coinsurance
Outpatient Surgery	20% Coinsurance		20% Coinsurance
Ambulance Service	20% Coinsurance		20% Coinsurance

Note: All Coinsurance applies **AFTER** deductible, unless otherwise noted.

MEDICAL BENEFITS (Continued)

Administered by Auxiant

	PPO PLAN - OPTION 1	PPO PLAN - OPTION 2	HDHP PLAN - OPTION 3
	In-Network	In-Network	In-Network
MENTAL HEALTH SERVICES			
Inpatient Services	20% Coinsurance		20% Coinsurance
Outpatient Services	$35 copay		20% Coinsurance
SUBSTANCE ABUSE SERVICES			
Inpatient Services	20% Coinsurance		20% Coinsurance
Outpatient Services	$35 copay		20% Coinsurance
OTHER SERVICES			
Maternity Office Visit	No Charge		20% Coinsurance
All other maternity hospital/ physician services	20% Coinsurance		20% Coinsurance
Chiropractic Services (20 visits plan year)	50% coinsurance, deductible waived		50% Coinsurance
Physical, Occupational and Speech Therapy Services	20% Coinsurance		20% Coinsurance
Skilled Nursing	20% Coinsurance		20% Coinsurance

Note: All Coinsurance applies **AFTER** deductible, unless otherwise noted.

Benefits listed are for in-network providers. To find a provider, go to www.Aetna.com/ASA

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EMPLOYEE CONTRIBUTIONS

BENEFIT PLAN	COST PER PAY PERIOD		
	PPO Plan Option 1	PPO Plan Option 2	HDHP Plan Option 3
Employee	$67.47	$13.95	$0.00
Employee + One	$307.41	$196.53	$135.22
Employee + Child(ren)	$282.50	$173.85	$106.22
Family	$486.49	$301.44	$237.89

HOW THE PLANS WORK

Three plans use the **Aetna** network and cover 100% of the cost for preventive care services like calendar year physicals and routine immunizations. The way you pay for care is different with each plan.

With the High Deductible Health Plan (HDHP), you pay the full negotiated cost for medical services and prescription drugs until you meet your Plan year deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the Plan year out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the Plan year. Your paycheck deductions for this plan are lower than the traditional PPO plan.

The PPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your Plan year out-of-pocket maximum. This plan has higher paycheck deductions than the HDHP.

	HDHP	PPO Plan
Per-paycheck Cost for Coverage	$	$$
Plan Year Deductible	$$	$
Plan Year Out-of-pocket Maximum	$$	$
Using the Plan	Pay less with each paycheck and more when you need care	Pay more with each paycheck and less when you need care
Spending Account Options	Health savings account (HSA) Dependent care Flexible Spending Account (FSA)	Health care Flexible Spending Account (FSA) Dependent care Flexible Spending Account (FSA)

PAYING FOR HEALTH CARE

Satanta District Hospital offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

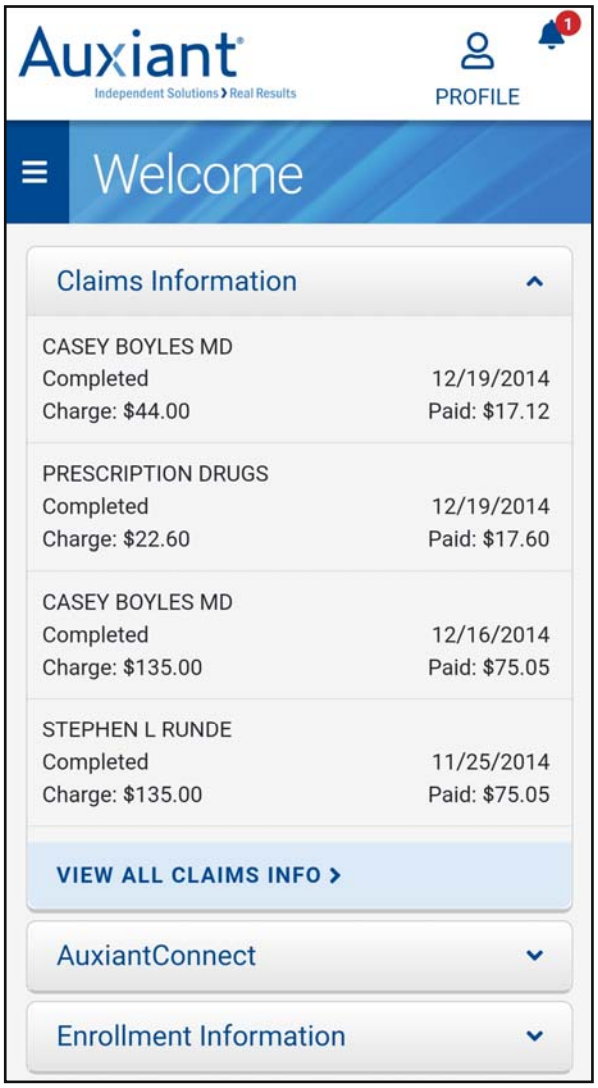
	HSA	FSA
What medical plan can I choose?	HDHP	PPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account. If you were previously enrolled in an FSA plan, all FSA funds must be used prior to contributing to an HSA.	All of the funds you elect for the Plan year are available on July 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	You may roll over up to $660 in unused funds at the end of the plan year. Funds in excess of $660 would be forfeited.
How do I pay for eligible expenses?	With your HSA Central debit card (You can also submit claims for reimbursement online at www.ASIFlex.com and www.HSACentral.net)	With your ASIFlex debit card (You can also submit claims for reimbursement online at www.ASIFlex.com) or through the mobile app.
How much can I contribute each year?	$4,300 for individual coverage or $8,550 for family coverage. Individuals over 55 may also qualify for an additional $1,000 catch-up contribution.	You can contribute $3,300 for individual coverage or $5,000 for family coverage in 2025
Can I change my contributions throughout the year?	Yes, you can log on to benefits.plansource.com to change your HSA contributions at any time	No, unless you have a qualifying life event
Can I still contribute if I am enrolled in Medicare?	You may not contribute to an HSA if you are enrolled in Medicare.	Yes, contributing to an FSA is still allowed under Medicare.

Auxiant Mobile App

AUXIANT MOBILE APPLICATION

Features and Benefits:

- Claim tracking with real time notification
- Electronic or printable ID cards
- Live Chat with Customer Service
- Access to enrollment, claims, benefits and benefit accumulators
- Links to PPO networks, PBM and other plan vendors



Please visit the app store and download our mobile app today!

Download on the App Store

GET IT ON Google Play

MANAGE YOUR PRESCRIPTIONS *EASILY* ONLINE AND ON THE GO.

Registration is easy. Please visit *myempirxhealth.com*

- EmpiRx Health prescription & claims history
- Mail-order service & refills
- Drug pricing
- Pharmacy search filter
- Benefits information
- ID card
- And so much more

How To Register

1. Navigate to myempirxhealth.com
2. Click on **Create An Account.**
3. Enter your email and click on **Send Verification Code.**
4. Check your email and enter the verification code.
5. Enter your information and click **Next.**
6. Create a username and password and click **Next.**
7. Enter the RxGRP and Member ID from your ID Card.
8. Once entered, click **Create My Account.**

Download the EmpiRx Health app.

GET IT ON Google Play

DOWNLOAD ON THE App Store

Each spouse and/or dependent over the age of 18 must create their own account in the portal and provide access to other family members in order for their Protected Health Information (PHI) to be shared.

EMPIRX HEALTH®

myempirxhealth.com | App available for iPhone & Android

EMERGENCY TRANSPORT

Administered by MASA Medical Transport Solutions

Emergency air or ground transportation often can lead to high out-of-pocket costs even for those with health insurance coverage. Protect your family from these costs with MASA's emergency transport coverage.

Benefits Information*	Platinum Plan	Emergent Plus Plan
Emergency Ground Transport	Included (US & Canada)	Included (US & Canada)
Emergency Air Transport	Included (US & Canada)	Included (US & Canada)
Repatriation	Included (US & Canada)	Included (US & Canada)
Non-Emergent Medical Air Transport *Must be pre-approved by MASA*	Included (Worldwide)	Included (US & Canada)
Visitor Transportation	Included (US, Canada, Mexico, & Caribbean)	Not Included
Vehicle Return	Included (US, Canada, Mexico, & Caribbean)	Not Included
Pet Return	Included (US, Canada, Mexico, & Caribbean)	Not Included
Portable Coverage	Yes	No; must upgrade to Platinum Plan to continue

BENEFIT PLAN	Cost Per Pay Period**	
	Platinum Plan	**Emergent Plus Plan**
Family Coverage *WITH* *GPHA Medical Plan Enrollment*	$16.50	$4.00
Family Coverage *WITHOUT* *GPHA Medical Plan Enrollment*	$19.50	$7.00

MASA provides coverage for the Primary Employee, Primary Employee's Spouse/Legal Domestic Partner, and Primary Employee's legal dependents up to the age of 26.

MASA allows you to be transported by **any emergency air or ground transport provider.*

***Employee must be covered by a health insurance plan to enroll in this benefit. Per IRS regulations, members enrolled in any Qualified High Deductible Health Plan must have met at least $1,650 of their individual medical deductible before MASA can pay any claims.*

Refer to benefit materials available during online enrollment for more details about this benefit.

DENTAL BENEFITS

Administered by Blue Cross & Blue Shield of Kansas

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Satanta District Hospital dental benefit plan.

SERVICES	PPO
Plan Year Deductible	$25 per person; $75 family limit
Plan Year Benefit Maximum	$1,500
Preventive Dental Services (Cleanings, Exams & X-rays.)	100%
Basic Dental Services (Fillings, Diagnostic Exams & Oral Surgery)	80% after deductible
Major Dental Services (Crowns, Dentures & Implants)	50% after deductible
Orthodontics	100% up to $1,500 3-year maximum

EMPLOYEE CONTRIBUTIONS

BENEFIT PLAN	COST PER PAY PERIOD
Dental	
Employee	$8.38
Employee + Spouse	$17.97
Employee + Child(ren)	$18.03
Family	$27.52

Benefits listed are for in-network providers. To find a provider, go to bcbsks.com or call 800.432.3900.

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VISION BENEFITS

Administered by MetLife

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	LOW PLAN IN-NETWORK (ANY VSP CHOICE PROVIDER)	HIGH PLAN IN-NETWORK (ANY VSP CHOICE PROVIDER)
Eye Exam — once every 12 months	$15 copay	$15 copay
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$15 copay	$15 copay
Lined Bifocal Lenses	$15 copay	$15 copay
Lined Trifocal Lenses	$15 copay	$15 copay
Lenticular Lenses	$15 copay	$15 copay
Frames — once every 12 months	$150 allowance every 12 months after $15 copay	$200 allowance every 12 months after $15 copay
Second Pair	N/A	2 pair eyeglasses, 1 pair of eyeglasses + contact lenses, or double contact lens
CONTACT LENSES — ONCE EVERY 12 MONTHS IF YOU ELECT CONTACTS INSTEAD OF LENSES/FRAMES		
Contact fitting and evaluation	$60 copay	$60 copay
Elective lenses	$150 allowance	$200 allowance
Necessary lenses	Covered in full	Covered in full

EMPLOYEE CONTRIBUTIONS

BENEFIT PLAN	COST PER PAY PERIOD	
Vision	**Low Plan**	**High Plan**
Employee	$5.41	$6.94
Employee + One	$10.31	$13.02
Employee + two or more	$17.16	$21.63

Benefits shown are for in-network providers. To find a provider call 855-638-3931 or visit metlife.com/insurance/vision-insurance/#find-a-provider and select the VSP Choice network.

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FLEXIBLE SPENDING ACCOUNTS

Administered by ASIFlex

You can save money on your healthcare and/or dependent day care expenses with a Flexible Spending Account (FSA). You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Healthcare FSA

Healthcare Spending Limit $3,300

The Healthcare Flexible Spending Account (FSA). This plan allows employees to save an average of 30% on eligible medical, dental, and/or vision care expenses by using pre-tax money! Contributions are deducted pre-tax in equal installments throughout the year from your paycheck and placed in a spending account for you to reimburse qualifying expenses. Some of the qualifying expenses include: deductibles, copays, coinsurance, dental care, and vision care.

Your plan has a 'Rollover' provision which means you can carry over up to $660 of your unused balance into the next plan year. Unreimbursed funds in excess of $660 at the end of the plan year will be forfeited.

Dependent Care FSA

Dependent Care Spending Limit $5,000

The Dependent Care FSA is also allows you to use pre-tax dollars to pay for daycare expenses for your children or adult dependents. With a dependent care FSA, the money must be in your account before you can request reimbursement.

Unreimbursed money left in your account after the end of the plan year will be forfeited.

Note: You are not able to take advantage of the Dependent Care Tax Credit and Dependent Care FSA in the same year. Consult your tax adviser for more information.

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Contact ASIFlex about your FSA Plans			
Phone:	**Online:**	**Email:**	**Mobile App:**
800-659-3035	ASIFlex.com	asi@asiflex.com	ASIFlex Self Service

LIFE INSURANCE BENEFITS

Administered by Sun Life

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Basic Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Satanta District Hospital. The company provides basic life insurance of up to 2 times your annual salary to a plan maximum of $750,000 at no cost to you. Dependent Life Insurance provides a $10,000 (not to exceed 50% of employee election) benefit to you if a covered dependent passes away. ($10,000 for children 1 day to 26 years old (not to exceed 50% of employee election))

Benefits are reduced to 67% at age 65 and to 50% at age 70. Your coverage ends at termination of employment or retirement.

Basic Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Satanta District Hospital provides AD&D coverage of up to 2 times your annual salary to a plan maximum of $750,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above.

VOLUNTARY LIFE AND AD&D INSURANCE

You may purchase additional Voluntary Life and Voluntary AD&D insurance. If you enroll yourself in these plans, you may also elect coverage for your dependents. If you enroll at your first opportunity, you are guaranteed coverage (up to $150,000 for yourself and up to $50,000 for your spouse) without answering medical questions.

Employee— 5 times your annual salary up to $500,000 maximum, in increments of $10,000 – Newly eligible guarantee issue of $150,000

Spouse— Up to $250,000 maximum, in increments of $5,000 (not to exceed 50% of employee election) – Newly eligible guarantee issue of $50,000

Children— Birth to 26 years old, up to $20,000 maximum, in increments of $2,000 (not to exceed 50% of employee election)

Your cost for coverage will be calculated for you during online enrollment. Benefits above the guaranteed issue amount may be applied for by completing the Evidence of Insurability (EOI) process.

Benefits are reduced to 67% at age 70 and to 45% at age 75.

If you are currently enrolled in Employee Life, and you have not been denied coverage previously, you have a guaranteed issue amount of up to $20,000 at each open enrollment with no EOI required. This is only available on the employee coverage. Any increase to spouse voluntary life will require EOI.

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DISABILITY INSURANCE

Administered by Sun Life

Satanta District Hospital also provides disability insurance through Sun Life at no cost to eligible employees. This benefit replaces a portion of your income if you become disabled and are unable to work.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-term Disability	You receive 60% of your weekly earnings up to $3,750 per week. Benefits begin after 60 calendar days of absence from work for a covered illness or injury and may continue for up to 18 weeks.	Employer
Long-term Disability	You receive 60% of your monthly earnings up to $15,000 per month. Benefits begin after 180 calendar days of absence from work or the end of your Basic Short Term Disability Maximum Benefit Duration, whichever is later and may continue until you reach the SSNRA To age 65, but not less than 60 Months—as long as you are still unable to work due to a covered disability.	Employer

FREQUENTLY ASKED QUESTIONS:

How does using my PTO or EIB affect my disability benefit payment?

To determine the benefit Sun Life will pay while you are disabled, they add your deductible sources of income (ie: PTO or EIB) and your disability earnings to your gross disability benefit.

If the calculation is more than 100% of your normal weekly earnings, they will subtract the overage from your disability benefit payment amount.

If the calculation is less than 100% of your normal weekly earnings, Sun Life will pay the full disability benefit.

What if a benefit is underpaid or overpaid?

Reimbursement will be made to Sun Life for any overpayments that they may make due to any reason. You must repay within 60 days unless they agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If Sun Life has underpaid a benefit for any reason, they will make a lump sum payment for that amount.

I'm planning to have a baby, how long will I receive benefits?

Short-term disability benefits typically end six weeks after your delivery date for a natural birth. For a C-section, disability benefits may be extended up to an additional two weeks, for a total of up to eight weeks beyond your delivery date. Please note that the Elimination Period will still apply. Benefit payments may extend beyond 6-8 weeks if there are medical complications. Your doctor must provide certification that the covered disability will last more than the initial six weeks.

Pre-Existing Conditions Exclusion:

A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine. If you submit a claim within 12 months of your insurance taking effect Sun Life will not pay any benefit for any pre-existing condition.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

What happens when I call for counseling support?

When you call, you will speak with a GuidanceConsultant℠, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You will receive counseling through the EAP up to 3 telephonic sessions per issue, per person, per calendar year. You can then set up an appointment to speak with the counselor over the phone.

What counseling services does the EAP provide?

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Contact EAPEssential Anytime

No-cost, confidential solutions to life's challenges.

Your ComPsych® GuidanceResources® program EAPEssential offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 800.460.4374
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPEssential

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

GGFL-1593

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TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPEssential

HOSPITAL INDEMNITY INSURANCE

Administered by Guardian Life

The hospital indemnity plan provides benefits in addition to your health insurance coverage to help protect you from financial hardship during a difficult time. This policy is portable giving you the ability to keep your coverage at the same rates even if you change jobs or retire.

This plan pays a cash benefit when you are admitted to a hospital for sickness or injury, whether or not these charges are covered by your medical plan.

Benefits Information*	
Hospital / ICU Admission	$500 / $1,000 per admission, limited to 1 admission per insured per benefit year
Hospital / ICU Confinement	$100 / $200 per day limited to 30 days per insured per benefit year
Portable Coverage	Yes
Age Limits	Children age birth – 26 years; Applicants over age 69 are not eligible to enroll.
***Benefits are not payable for giving birth within the first 9 months of coverage.*	

BENEFIT PLAN	Cost Per Pay Period
Employee Only	$6.76
Employee + Spouse	$12.70
Employee + Children	$10.38
Employee + Family	$16.32

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CANCER INSURANCE

Administered by Guardian Life

The cancer plans provide benefits in addition to your health insurance coverage to help protect you from financial hardship during a difficult time. Policies are portable giving you the ability to keep your coverage at the same rates even if you change jobs or retire.

These plans pay a lump-sum cash benefit for certain procedures, screenings, and treatments related to a covered cancer diagnosis, in addition to whatever your medical plan covers. Easy enrollment with no medical questions.

Benefits Information*	Low Plan*	High Plan*
Initial Diagnosis Benefit	$1,000	$3,000
Radiation Therapy or Chemotherapy	Up to $5,000 per year	Up to $10,000 per year
Anti-Nausea Medication	$50 per day, up to $150 per month	
Experimental Treatment	$100 per day, up to $1,000 per month	
Surgical Benefit	Schedule amounts up to $4,125	
Hospital Confinement	$300 per day for first 30 days; $600 per day for 31st day thereafter	
Wellness Benefit	$50 per covered person per year	$100 per covered person per year
Portable Coverage	Yes; though ported coverage terminates at age 70.	

BENEFIT PLAN	Low Plan	High Plan
Employee Only	$7.62	$11.68
Employee + Spouse	$10.53	$17.69
Employee + Children	$10.12	$15.87
Employee + Family	$13.03	$21.87

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ACCIDENT INSURANCE

Administered by Guardian Life

The accident plan pays a cash benefit for covered injuries, treatments, and services in addition to whatever your medical plan may cover. Easy enrollment with no medical questions. This policy is portable giving you the ability to keep your coverage at the same rates even if you change jobs or retire.

Benefits Information*	
Accidental Death Benefit	Employee $40,000; Spouse $20,000; Child $10,000
Dislocations	Up to $5,400
Fractures	Up to $6,750
Hospital / ICU Admission	$1,000 / $2,000
Hospital Confinement	$225 per day, up to 1 year
Hospital ICU Confinement	$450 per day, up to 15 days
Emergency Room Treatment	$175
Urgent Care Treatment	$75
Chiropractic Visits	$25 per visit, up to 6 visits
Wellness Benefit	$100 per covered person per year. Qualify with flu shot or many other health screenings.
Portable Coverage	Yes

BENEFIT PLAN	Cost Per Pay Period
Employee Only	$9.00
Employee + Spouse	$16.93
Employee + Children	$14.51
Employee + Family	$22.45

**This is just a brief overview. See Summary of Benefits for more information. The above comparison is intended for informational use only. It does not include all the benefit provisions, limitations, and qualifications. If this information conflicts in any way with the legal plan document, the legal plan document will prevail.*

CRITICAL ILLNESS INSURANCE

Administered by Guardian Life

Treatment of critical illnesses can lead to unexpected expenses that create an additional financial burden. Critical illness insurance helps fill in the gaps that medical insurance does not cover. This may include travel to treatment centers, ongoing household bills, co-pays to experimental treatment, and everyday expenses like groceries, rent, and mortgage.

These plans provide benefits in addition to your health insurance coverage to help protect you from financial hardship during a difficult time. Policies are portable giving you the ability to keep your coverage at the same rates even if you change jobs or retire.

- Pays initial benefit ($10,000 or $20,000) for: Heart Attack, Invasive Cancer, Stroke, Major Organ Failure, Renal Failure, Paralysis, Advanced Alzheimer's and more
- Additional benefit if a second critical illness occurs
- Recurrence benefit if certain critical illness occurs more than once, at least 12 months apart
- Issue-age: your cost will not increase due to age.
- Coverage is portable
- $50 annual wellness benefit for each covered person

BENEFIT PLAN	Cost Per Pay Period	
	$10,000 Plan	**$20,000 Plan**
Age 18-34	$1.61	$3.22
Age 35-49	$5.52	$11.04
Age 50-59	$11.61	$23.22
Age 60-69	$13.21	$26.42
Age 70+	$34.84 *Benefit reduced to $5,000*	$69.68 *Benefit reduced to $10,000*
Note: Costs shown above **double** if enrolling in Employee + Spouse coverage. Dependent children under 26 are eligible for coverage at no additional cost.		

This is just a brief overview. See Summary of Benefits for more information. The above comparison is intended for informational use only. It does not include all the benefit provisions, limitations, and qualifications. If this information conflicts in any way with the legal plan document, the legal plan document will prevail.

LEGAL SERVICES and ID THEFT PROTECTION

Administered by LegalShield and IDShield

LegalShield Plan

LegalShield provides legal assistance and consultation on personal legal matters through a network of attorneys.

- Personal legal advice on unlimited issues
- Letters or calls made on your behalf
- Lawyers prepare your Will, your Living Will, and your Health Care Power of Attorney
- Review contracts and documents
- Moving Traffic Violations (available 15 days after enrollment)
- 24/7 Emergency Access for covered situations
- Uncontested divorce, separation, adoption and/or name change representation (available 90 days after enrollment in family tier)
- Trial Defense (if named respondent in covered lawsuit)
- Ability to keep same coverage at same rates even if you change jobs or retire

Identity Theft Protection Plan

IDShield protects your identity and privacy by monitoring your identity, credit, financial accounts, social media accounts, and providing device management.

- Privacy and Security Monitoring: Monitoring your name, SSN, financial information, email address, phone numbers, driver license, medical ID numbers, financial activity alerts and quarterly credit score tracking, and more!
- Consultation: 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications, and more!
- Full Service Restoration: Identity recovery by a dedicated Licensed Private Investigator who will restore your identity to its pre-theft status, guaranteed.
- Ability to keep same coverage at same rates even if you change jobs or retire

BENEFIT PLAN	Cost Per Pay Period		
	LegalShield	IDShield	Legal & IDShield Combo
Employee Only	$7.48	$4.23	$11.70
Employee + Family	$7.98	$7.98	$14.45

This is just a brief overview. See Summary of Benefits for more information. The above comparison is intended for informational use only. It does not include all the benefit provisions, limitations, and qualifications. If this information conflicts in any way with the legal plan document, the legal plan document will prevail.

LONG-TERM CARE INSURANCE

Administered by UNUM

Employees working at least 30 hours per week are eligible for long-term care (LTC) insurance through Unum. This coverage protects you from a difficult decision: whether to exhaust your savings or liquidate your assets if you or a loved one needs LTC. This coverage helps prepare you for the financial realities of LTC and can help you maintain control of important decisions, such as:

- Who would take care of me?
- Where would I receive my care?
- Would I be a burden on my children if my savings wouldn't cover my care?

Employer Provided Base Benefit:

Plan 1 / $1,000 monthly benefit / 3 year benefit duration

Customize Your Plan:

Choose your benefits:

- Monthly Benefit: $1,000 – $8,000 (Newly Eligible Guarantee Issue up to $6,000)
- Benefit Duration: 3 years, 6 years, or Lifetime (Newly Eligible Guarantee Issue up to 6 years)

Coverage also available for spouse and other family!

- See benefits summary for more details.
- Changes may be made during open enrollment.

Choose your level of care:

- Plan 1 – Nursing Home & Pro-Home Care
- Plan 2 – Plan 1 Benefits & Choice Home Care
- Plan 3 – Plan 1 Benefits & Inflation Protection
- Plan 4 – Plan 2 Benefits & Inflation Protection

Visit UnumInfo.com/Satanta for additional information, including a rate calculator.

Frequently Asked Questions:

Won't my other insurance cover long-term care?

Unfortunately, no. Medical insurance and Medicare are designed to pay for specific care for acute conditions — not for long term help with daily living. Medicaid only helps with long term care expenses after you have depleted virtually all your assets. Only long-term care insurance may cover those costs and help you to maintain as much of your assets as possible.

Do I need to be in a nursing home to use this?

No, all plans include a home health option. This allows you to use your benefit to pay for an aide to come to your home. For an extra premium, Choice Home Care plans allow you to pay a family member or friend to provide care.

Why buy coverage when I'm young?

The younger you are, the more affordable the rates. Once enrolled, your rates will not increase due to your age. By enrolling through your employer, you may have access to more affordable rates than you can find elsewhere.

RETIREMENT SAVINGS PLAN

Administered by OneAmerica

Satanta District Hospital provides a retirement savings program to help you prepare for retirement.

What types of contributions may be made?

Employee Voluntary Contributions

Employees may voluntarily contribute traditional (pre-tax) and/or Roth (after-tax) contributions up to the IRS limits each year. 2025 limit: $23,500. Employees 50 years or older are eligible to defer an additional $7,500 referred to as a 'catch-up contribution'. Employees age 60-63 are eligible for an increased catch-up contribution of $11,250 instead of $7,500.

Employer Matching Contributions

For all employees who work 1 year of service (defined as 1,000 hours or more) and have attained age 21, the employer will match the employee's contribution made to the voluntary plan. The matching contribution will be equal to 100% of deferrals up to 4% of compensation, up to a maximum salary of $350,000.

Employee Mandatory Contributions

All employees who work 1 year of service (defined as 1,000 hours or more) and have attained age 21, will contribute 2% of their compensation into the plan, up to a maximum salary of $350,000.

Employer Mandatory Contributions

For all employees who work 1 year of service (defined as 1,000 hours or more) and have attained age 21, the employer will contribute 2% of their compensation into the plan up to a maximum salary of $350,000.

Does my plan have a vesting schedule?

Employees are always 100% vested in their contributions.

Employer contributions are subject to the following vesting schedule:

Years of Service	Vested Percentage
Less than 2	0%
2 but less than 3	20%
3 but less than 4	40%
4 but less than 5	60%
5 but less than 6	80%
6 or more	100%*

*100% vesting also occurs at age 62

RETIREMENT SAVINGS PLAN (Continued)

Administered by OneAmerica

How much should I consider contributing to my retirement?

Many financial professionals recommend saving between 10% – 15% of your earnings toward retirement each year. This can be a combination of employee and employer contributions. Contact Human Resources to increase or change your contribution!

What investment options are available?

Your plan offers a wide variety of investment options. You may select your own portfolio, consider a Target Date option, or a professionally managed account service. If you enroll without selecting investments, contributions will automatically be made to a diversified, age-appropriate, Target Date Investment Option. We encourage you to contact Gallagher 785-560-6013 to learn more.

How can I access my account?

- Go to: OneAmerica.com/login
- For initial login, click 'Create an Account'. Under 'Individual Account' click 'Register', then 'I have a retirement plan'
- Enter your information including your plan number: G32359
- Select 'Next' to set up your User ID & Password
- If you've forgotten your login information, you may select 'Forgot ID or Forgot Password' or call OneAmerica's Customer Engagement Center: 800-249-6269

Have more questions or need assistance?

We encourage you to contact your Gallagher representative to learn more.

Kendra Kaiser QKA®
Retirement Plan Consultant
Gallagher Fiduciary Advisors, LLC
215 Southwind Place, Suite 201, Manhattan, KS 66503
D (785) 560 6013
kendra_kaiser@ajg.com

FREQUENTLY ASKED QUESTIONS

How can I learn more about the benefits in this guide?

Download more information from your 'PlanSource document library' by logging into benefits.plansource.com. You are also welcome to contact the Gallagher Benefit Advocate team or Human Resources to learn more!

When can I make changes to my benefits?

Benefit changes can be made during the annual open enrollment period. Benefit changes can also be made if you experience a qualifying life event such as a marriage, divorce, birth of a child, etc.

How can I check to see which benefits I'm enrolled currently?

Your current benefit elections may be viewed by logging in to benefits.plansource.com. Refer to the online enrollment instructions later in this guide to learn more.

Do I have to go through the online benefits enrollment process?

All eligible employees are required to complete the online enrollment process. Even if you are not making any changes to your benefits, it is still **very important** for you to complete the process.

How can I file a claim?

- Access available forms in 'PlanSource Document Library' at benefits.plansource.com
- Complete claim form for appropriate benefit
- Attach any required supporting documentation
- For fastest processing, online submission via the carrier's website is recommended

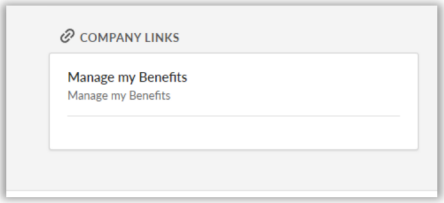
▶ Make sure you have the coverage you need!

Don't miss this opportunity to enroll or change your benefits! Please follow the Online Enrollment Instructions on the next two pages to ensure you have the coverage you need. Even if you are not making any changes to your benefits, it is still ***very important*** for you to complete the process.

Online Enrollment Instructions

1. Log into BambooHR.

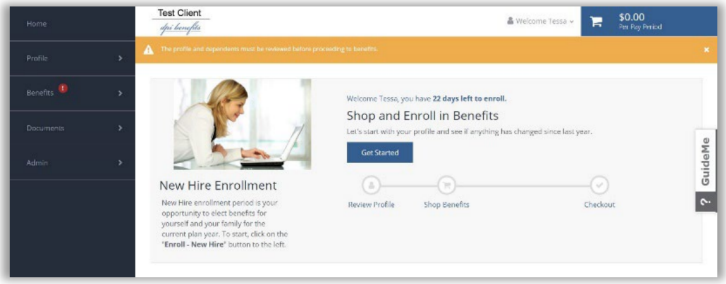
Use the login credentials HR assigned you. In the menu along the left side, toward the bottom, click Manage My Benefits.



2. Home screen.

Click Get Started to begin your enrollment.

***Tip:** Benefit summaries, claim forms, plan info, etc. are available for download year-round in the Documents menu!*



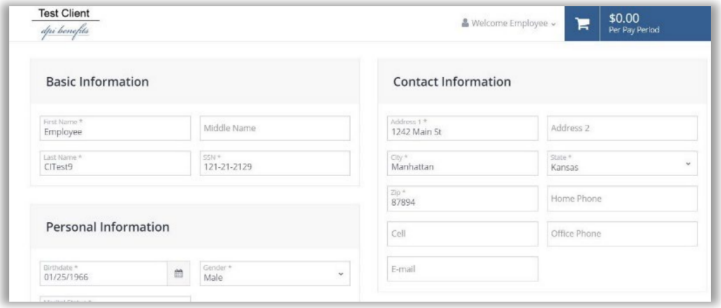
3. Review your profile.

Verify your personal information.

Be sure to enter your email address to receive important benefits information.

Scroll down, click SAVE.

Click Next: Review My Family.



Make sure **ALL** your dependents (including your spouse) are listed as family. Click Add Family Member to add anyone.

***Note:** Dependents **NOT** listed here will not be enrolled in ANY benefits, including applicable employer-paid benefits. As you progress through your enrollment you can still choose which dependents to cover for each benefit.*

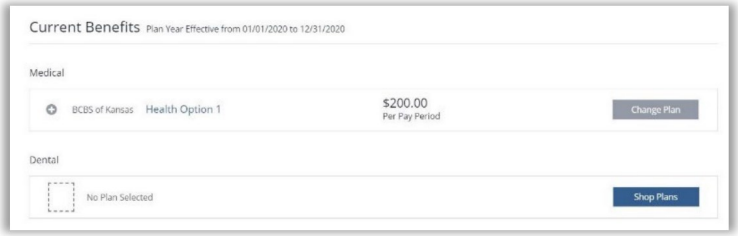
Click Next: Shop for Benefits.

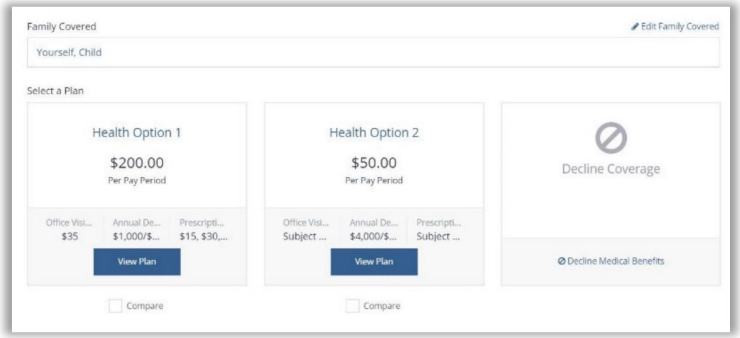
4. Shop for your benefits.

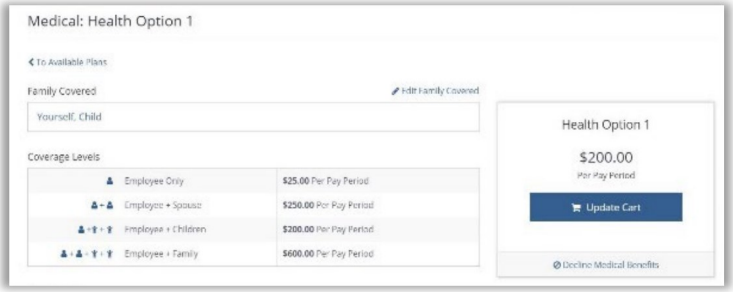
Change Plan. You can change your plan and/or covered dependents.

Shop Plans. If you are eligible for a benefit, but not currently enrolled, you can view plan details and see the cost for different levels of coverage here.

***Tip:** Benefit summaries are available in the Documents library on your Home screen.*







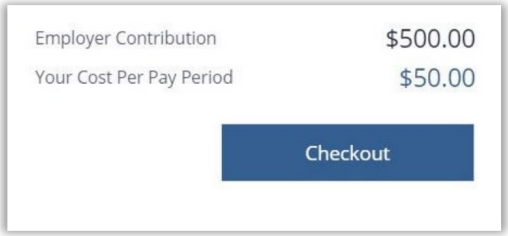
You must make a decision on each benefit:

To enroll in coverage, select Update Cart.

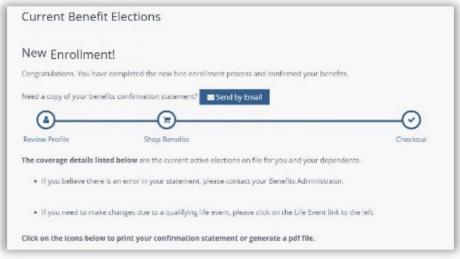
Otherwise, select Decline Benefit.

Click Review and Checkout for a final review of your elections and declinations.

You **must** click the Checkout button to complete your enrollment.



Congratulations! Once you see the Enrollment Complete confirmation screen, you are done! We recommend saving your confirmation statement, click Send by Email.



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you. Get assistance with:

1. **Insurance cards**
   Are you missing your insurance cards, need replacement cards or need to get in touch with an insurance carrier?
2. **Benefits questions**
   Do you need help with specific benefits questions relating to how plans work, coverage questions or in-network benefits?
3. **Eligibility rules**
   Who can be covered under the plan and when?
4. **Provider search**
   Do you need help finding an in-network or specialty provider?
5. **Prescription/pharmacy issues**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help getting a pre-authorization on your medication?
6. **Claims**
   Are you unsure if your insurance will pay for a certain procedure? Did you receive a bill from a doctor and don't know why?

Hours of Operation

Monday–Friday
8 a.m.–6 p.m. in local time zone

Connect With Us

Satanta District Hospital

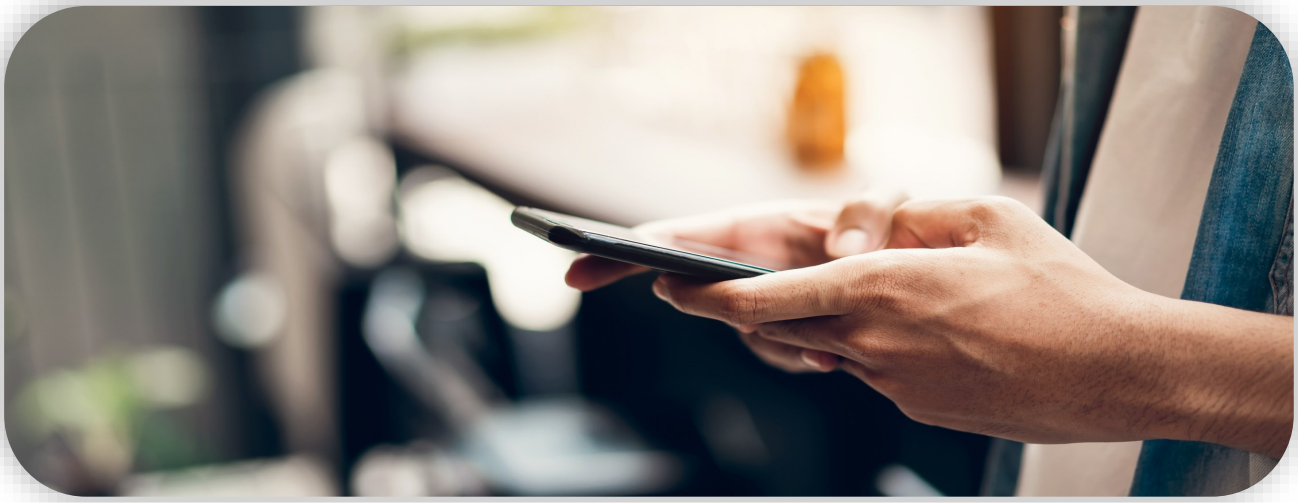
(833) 261-6585
bac.satantahospitalcso@ajg.com

ajg.com **The Gallagher Way.** Since 1927.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Auxiant	800.245.0533	www.Auxiant.com
Prescription Drugs	EmpiRx	877.323.0783	www.MyEmpiRxHealth.com
Emergency Transport	MASA Medical Transport Solutions	877.503.0585	www.MASAMTS.com
Dental	Blue Cross & Blue Shield of Kansas	800.432.3900	www.BCBSKS.com
Vision	MetLife	855.638.3931	www.MetLife.com/Vision
Health Savings Account	HSA Central Bank	833.232.4676	www.HSACentral.net
Flexible Spending Account	ASI Flex	800.659.3035	www.ASIFlex.com
Life and Disability	Sun Life	800.247.6875	www.SunLife.com/Account
Employee Assistance Program	ComPsych Guidance Resources	800.460.4374	www.GuidanceResources.com
Hospital Indemnity, Cancer, Accident, Critical Illness	Guardian	888.482.7342	www.GuardianLife.com
Legal Services	LegalShield	866.470.1694	www.LegalShield.com
Identity Theft Protection	IDShield	888.494.8519	www.IDShield.com
Long-Term Care	Unum	866.679.3054	www.UnumInfo.com/Satanta
Retirement Savings Plan	OneAmerica	800.249.6269	OneAmerica.com/Login
PlanSource Online Enrollment	GIS Benefits	540.280.6345	https://benefits.plansource.com
Benefit Advocate Center (BAC)	Gallagher	833.261.6585	bac.satantahospitalcso@ajg.com



LEGAL NOTICES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: PPO Plan Option 1 (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $3,000 deductible)
Plan 2: PPO Plan Option 2 (Individual: 20% coinsurance and $2,500 deductible; Family: 20% coinsurance and $5,000 deductible)
Plan 3: HDHP Plan Option 3 (Individual: 20% coinsurance and $5,000 deductible; Family: 20% coinsurance and $10,000 deductible)

If you would like more information on WHCRA benefits, please call your Human Resources at 620.649.2200.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Satanta District Hospital is committed to the privacy of your health information. The administrators of the Satanta District Hospital Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 620.649.2200.

HIPAA Special Enrollment Rights

Satanta District Hospital Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Satanta District Hospital Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at 620.649.2200.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Satanta District Hospital

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Satanta District Hospital 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. **Satanta District Hospital has determined that the prescription drug coverage offered by the medical 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 to December 7th.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Satanta District Hospital coverage will not be affected. You can keep the coverage if you elect part D; however, prescription drug coverage under the plan does not pay secondary to any other coverage.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Satanta District Hospital 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 Satanta District Hospital 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:	**July 01, 2025**
Name of Entity/Sender:	**Satanta District Hospital**
Contact—Position/Office:	**Human Resources**
Office Address:	**401 Cheyenne**
	Satanta, Kansas 67870-8748
	United States
Phone Number:	**620.649.2200**

Notice of Non-creditable Coverage

Important Notice from Satanta District Hospital

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Satanta District Hospital 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. **Satanta District Hospital has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Satanta District Hospital Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. **You can keep your current coverage from the Satanta District Hospital Health Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

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 to December 7th.

However, if you decide to drop your current coverage with Satanta District Hospital, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Satanta District Hospital plan.

Since you are losing creditable prescription drug coverage under the Satanta District Hospital plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Satanta District Hospital plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Satanta District Hospital coverage will not be affected. You can keep the coverage if you elect part D; however, prescription drug coverage under the plan does not pay secondary to any other coverage.

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

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 Satanta District Hospital 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:

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- 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).

Date:	**July 01, 2025**
Name of Entity/Sender:	**Satanta District Hospital**
Contact—Position/Office:	**Human Resources**
Office Address:	**401 Cheyenne**
	Satanta, Kansas 67870-8748
	United States
Phone Number:	**620.649.2200**

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This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting