2024
BENEFITS GUIDE

Your Benefits. Your Choices. Your Health.

ST. FRANCIS COLLEGE EST. 1859

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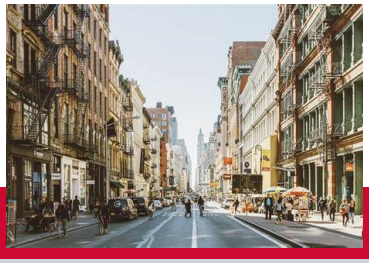

ADVOCACY

BenefitsVIP®
Help starts here.

HELP STARTS HERE

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

For service that's confidential and responsive, contact:

866.293.9736

Monday—Friday
8:30am—8:00pm (ET)
Fax: **856.996.2775**
Solutions@benefitsvip.com

Questions answered here

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP.com

WEBSITE
Stay informed with the latest health news, biometric tools, calculators and information at **benefitsvip.com**!

BLOG
HealthDiscovery.org is a lifestyle blog with wellness articles, tips, quizzes, recipes, and more!

2024 BENEFITS OPEN ENROLLMENT

It's that time of year — Benefits Open Enrollment!

The Open Enrollment period begins, Monday, November 20, 2023 through Friday, December 8, 2023. During this time, you will be able to make changes to your current benefit elections which will take effect January 1, 2024. Open Enrollment is the *only* period of time during the year when you are permitted to make changes to your benefits coverage without experiencing a qualifying event*.

2024 Plan Year Benefits—What You Need to Know:

No Increase in Medical and Dental Premiums - Despite rising inflation and Medical Premiums Increasing 10%** for 2024 on average, our Medical and Dental Premium deductions will remain unchanged for 2024.

Increase to HSA Seeding - The College funded amount will increase from $750 to $1,000 for Single and from $1,500 to $2,000 for Family coverage if you elect the HDHP plan. Important note: Beginning in 2024, deposits to your HSA account will be spread over 26 pay periods rather than one (1) annual deposit in January.

Retirement Plan Modification – Beginning with the 2024 Plan Year, the College funded deposits to your retirement account will be made on a quarterly basis (currently monthly). Important note: Going forward, the College shall review its finances on a quarterly basis and, upon each such review, shall, in its sole discretion, be permitted to make deposits quarterly on or about April 15, 2024, July 15, 2024, October 15, 2024 and January 15, 2025. For 2024 we are targeting a range of 5-7% of your base salary (currently 5%). If you are not already doing so, we encourage you to participate in the College sponsored 403(b) Salary Deferral Retirement Plan.

Follow these steps to enroll in the 403b: 1) Go to: TIAA.org/stfranciscollege 2) Select *Ready to Enroll* 3) Select the plan.

Life Insurance Benefit Change - Beginning 2024 our College paid Life Insurance Benefit will change from 2x annual salary to 1x annual salary. You will have the opportunity during Open Enrollment to enroll in or increase your Supplemental Life Insurance benefit without evidence of insurability up to the guaranteed issue.

Revised Vacation Policy for Administration and Staff (Non-Faculty) – Beginning 2024, we will be permitted to carry-over up to 5 accrued/unused vacation days approved in advance by your Supervisor. The vacation accrual calendar begins September 1st and ends August 31st. Any unused carry-over vacation days will be forfeited after November 30th. Beginning April 1, 2024, if your employment ends with the College for any reason, the College will no longer pay out any accrued unused vacation days.

**Qualifying Event as defined by the IRS include marriage, birth of a baby, adoption of a child or loss of coverage etc. For additional details contact the Office of Human Resources.*

***Aetna current book of business trend.*

2024 BENEFITS OPEN ENROLLMENT

Please Note:

- If you are currently enrolled with no changes to your benefits, your enrollment will automatically resume in 2024. You do not need to complete the 2024 Open Enrollment Process.
- If you are currently enrolled with medical, dental and vision benefits, and choose to make any changes or waive benefits for 2024, you must complete the 2024 Open Enrollment process.
- If you waived your benefits in 2023 and you wish to waive benefits in 2024, you do not have to complete the Open Enrollment process.
- If you wish to elect a Flexible Spending Account / Limited Flexible Spending Account for 2024, you must complete a 2024 FSA Enrollment / Change Form.
- If you waived medical, dental and vision benefits in 2023 and wish to enroll in these benefits for 2024, you must complete the 2024 Open Enrollment Process.

The Office of Human Resources is here to guide you through the enrollment process.

This year, Corporate Synergies will host Information Session as follows:

- **Webinar - Monday, November 20th / 2:00 pm to 3:00 pm**

  Zoom link: https://sfc.zoom.us/j/2736094191

- **Webinar - Tuesday, December 5th / 2:00 pm to 3:00 pm**

  Zoom link: https://sfc.zoom.us/j/2736094191

We look forward and encourage your participation in these sessions. If you cannot attend one of the sessions, we will gladly share a recording of a session upon request.

OPEN ENROLLMENT TO DO LIST

Please review the steps below to enroll or change your 2024 benefit elections.

What You Need to Do:

Step 1: Enroll or change your existing medical, dental or vision coverage here —> 2024 Open Enrollment

Step 2: Complete Affidavit of Non-Tobacco Use (required for new medical elections/changes) here —> 2024 Affidavit of Non-Tobacco Use

Step 3: Flexible Spending Account (FSA) participants make elections here —> 2024 General FSA

Step 4: Health Savings Account (HSA), Limited Purpose FSA make elections here —> 2024 HSA/ Limited Purpose FSA

Step 5: Transit and Parking/Benefit make elections here —> 2024 Commuter Benefits

It is important for employees to review their benefit plans and carefully consider all available options.

We strongly encourage you to attend one of the upcoming Information Sessions to learn more.

The enrollment period will close on **Friday, December 8, 2023 at 5pm.**

Please direct all questions to HR@sfc.edu

All the best in good health,

The Office of Human Resources

SFC ST. FRANCIS COLLEGE EST. 1859

FEQUENTLY ASKED QUESTIONS AND ANSWERS

Are there Restrictions Concerning my Eligibility to Enroll in the Health Savings Account ("HSA") and/or the Health Reimbursement Account ("HRA") and/or the Flexible Spending Accounts in Conjunction with my Medical Plan Elections?

Yes, the Federal government heavily regulates participation in these plans. For example, employees will not be eligible to open or contribute to an HSA, or receive St. Francis' contributions if they are currently enrolled in a non-HSA qualified medical plan. This includes a medical FSA, Medicare plan, or a spouse's non-HSA qualified Medical plan. For those employees who elect the High Deductible Health Plan and currently have a medical FSA, your balance must be completely depleted as of December 31, 2023 in order to be able to open and contribute to an HSA. In the event you have remaining FSA funds on January 1, 2024, your Health Savings Account election will not become effective until April 16, 2024.

- If you select the High Deductible Health Plan and are enrolled in Medicare, you will not have the option to contribute to an HSA.
- You do however have the option to enroll in a Health Reimbursement Account (HRA) and you also will remain eligible to open and contribute to a Flexible Spending Account (FSA) to help fund the rest of your deductible on a pre-tax basis.
- Please note that IRS regulations for HRA's differ significantly with those for HSAs. For example, if you retire or terminate from College employment, the funds provided by the College into your HRA will revert back to the College. Please see described on pages 20-21, the differences between the HSA, HRA and FSA programs for the 2024 plan year.

Who is Eligible to participate in the Medical, Dental and Vision Plans?

All full and part-time employees (working 21+ hours per week) are eligible to enroll in the Aetna medical program, and current employees can enroll or make changes during Open Enrollment or within 30 days of a qualifying event. Employees can also add the following eligible dependents to their plan:

- Spouse
- Children through the end of the calendar year in which they turn 26. Children include step-children, legally adopted children or any single child living in the household that can be claimed as a dependent as defined in the Internal Revenue Code;
- Dependent, unmarried children between ages 26 and 30, not eligible for coverage under any other NY-insured or self-insured employee health plan. This "Young Adult Option" is not eligible for an employer contribution towards the premium. Please contact Benefits VIP or Human Resources for additional information.

How do I Receive my Medical Plan Tobacco Discount?

The College will continue to offer a discount to those who either certify that they are not a "tobacco-user"[1] or who complete an online customized smoking cessation program. Please contact any of us in the Office of Human Resources to obtain further information about the College's smoking cessation program for employees through the American Lung Association.

[1]A "tobacco-user" for the purposes of this program is a benefits-eligible employee enrolled in the College-sponsored medical plan who uses tobacco products more than once a month. Tobacco products include cigarettes, chewing tobacco, smokeless tobacco, electronic cigarettes that involve the use of tobacco or tobacco products, cigars, clove cigarettes, pipes or any other smoking material or device (e.g., hookah, bidis, kreteks)

BENEFITS HIGHLIGHTS

AETNA MEDICAL PLANS

For the 2024 plan year, St. Francis will continue to offer a High Deductible Health Plan with In-Network and Out-of-Network benefits and a POS Plan with In-Network and Out-of-Network benefits. You do not need a referral to see a specialist for either plan.

The Aetna High Deductible Health Plan ("HDHP") continues to be the most affordable option. This plan is designed for those employees who use Aetna's large In-Network group of providers. This plan permits employees and the College to contribute funds directly into the Health Savings Accounts (HSA) of participating employees. With the exception of preventative care, employees enrolled in the HDHP will be required to meet an annual deductible before plan coverage begins.

The Aetna POS "High" Plan continues to be cost prohibitive for most employees. It therefore remains important to consider that the High Plan is generally a viable option only for those who are concerned that they may routinely and often see providers who are outside the Aetna network. If you are uncertain about whether or not your providers are in or out of the Aetna network, we strongly encourage you to log-in to your Aetna account at www.aetna.com and search their provider directory.

Employees who participate in the HDHP, the College will in 2024 contribute into your Health Savings Account ("HSA") or Health Reimbursement Account for Medicare enrollees ("HRA"), 33% of the cost of the annual deductibles and maximum HSA contributions are shown below. Please note that the College's contribution to your HSA is counted toward the annual maximum.

For those employees who contribute to their Health Savings Accounts, please note the 2024 IRS pre-tax contribution limits shown below. We strongly encourage participants to review their HSA balances at www.payflex.com and if desired, change the amount of their pre-tax contributions. Please note however that contribution changes may also be made to your HSA on the first pay date of any month throughout the year.

ANNUAL CONTRIBUTIONS	2024 IRS MAXIMUM	EMPLOYER CONTRIBUTION
Individual HDHP Coverage	$4,150	33% of the $3,000 HDHP Deductible ($1,000)
Family HDHP Coverage (includes Single + 1)	$8,300	33% of the $6,000 HDHP Deductible ($2,000)
Additional "Catch-up" Contribution Limits for those 55 or older	$1,000	N/A

BENEFITS HIGHLIGHTS

HIGHLIGHTS OF THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

The HDHP should only be utilized as an Aetna in-network plan. This plan allows you to go directly to a primary care physician or to a specialist. **Please see the 2024 HDHP rates on page 11 of this guide**.

With the exception of preventative care, employees enrolled in the HDHP will be required to meet an annual deductible before plan coverage begins.

For 2024, the annual deductibles remain unchanged from 2023 as follows:

- $3,000 deductible for single coverage;
- $6,000 for employee + 1 and Family coverage. Under Family coverage, the entire deductible can be met by one member in the family, or, by a combination of all family members covered under the plan before coverage begins. After this deductible is met, In-Network services will be 100% covered by Aetna.

Most employees who enroll in the HDHP will have the option to open and contribute to a Health Savings Account (HSA) on a pre-tax basis to pay for health plan expenses. The 2024 maximum HSA contribution is $4,150 for an individual plan and $8,300 for a family plan (including employee +1 coverage). If you are age 55 or older you may contribute an additional $1,000 into your HSA account.

Any remaining funds in the HSA at the end of the year can be rolled over to help pay for expenses in subsequent years. For the 2024 plan year, St. Francis will contribute 33% of the annual deductible to help fund a portion of the deductible for those employees that are enrolled in the HDHP and open an HSA account.

Employees enrolled in Medicare who select the HDHP are not permitted to open up a Health Savings Account, so they should instead enroll in a Health Reimbursement Account (or “HRA”). For the 2024 plan year, St. Francis will contribute 33% of the annual deductible to help fund a portion of the deductible for those employees that are enrolled in the HDHP and open an HRA.

HIGHLIGHTS OF THE POS HIGH PLAN

The POS High Plan has both in-network and out-of-network benefits and allows you to go directly to a primary care physician or to a specialist with the same co-pay of $25. The High Plan uses Aetna’s Managed Choice POS (Open Access) Network and has the same prescription drug benefits ($15/$25/$40 copays). **Please see the 2024 POS High Plan rates on page 13 of this guide**.

MEDICAL BENEFITS

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MANAGED CHOICE POS (OPEN ACCESS)
HIGH DEDUCTIBLE HEALTH PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	**Individual:** $3,000 **Family:** $6,000	**Individual:** $15,000 **Family:** $45,000
Out-of-Pocket Maximum	**Individual:** $3,000 **Family:** $6,000	**Individual:** $30,000; **Family:** $90,000
Coinsurance	You pay 0% Aetna pays 100%	You pay 30%* Aetna pays 70%*
Preventive Care		
Adult Preventive Care	No charge	30% coinsurance*
Adult Annual Physical Exam	No charge	30% coinsurance*
Well-Child Care	No charge	No charge
Inpatient Hospital	No charge*	30% coinsurance*
Outpatient Care		
Primary care physician office visits	No charge*	30% coinsurance*
Specialist office visits	No charge*	30% coinsurance*
Outpatient facility surgery	No charge*	30% coinsurance*
Laboratory and X-ray	No charge*	30% coinsurance*
Complex Radiology *(MRIs, MRAs, CT Scans, Pet Scans)*	No charge*	30% coinsurance*
Emergency Care		
Ambulance (medically necessary)	No charge*	No charge*
At hospital emergency room	No charge*	No charge*
Urgent Care	No charge*	30% coinsurance*
Maternity Care		
Preventative Prenatal and Post-natal care	No charge	30% coinsurance*
Hospital services for mother and child	No charge*	30% coinsurance*
Mental Health/Substance Abuse		
Inpatient	No charge*	30% coinsurance*
Outpatient	No charge*	30% coinsurance*
Prescription Drugs **Annual Deductible**	Subject to plan deductible	Subject to plan deductible
Retail Pharmacy (30 day supply) Tier-1/Tier-2/Tier-3	100%* (all tiers)	30%* (all tiers)
Mail Order (90 day supply) Tier-1/Tier-2/Tier-3	100%* (all tiers)	30%* (all tiers)

*after deductible is met

GLOSSARY

Deductible
An amount you could owe during a coverage period (usually one year) for health care services before your insurance plan starts to pay.

Out-of-Pocket Maximum/Limit
The most you could pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (30%, for example). After the deductible is met, you will pay 30% of the costs.

Copayment
A predetermined (flat) fee an individual pays for health care services. The amount can vary by the type of covered health care service.

Primary Care Physician (PCP)
A physician who directly provides or coordinates a range of health care services for a patient.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

HDHP CONTRIBUTIONS

Single Coverage - Bi-Weekly Costs		
Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$23.26	$25.34
$40,000-$49,999	$37.38	$39.46
$50,000-$59,999	$45.69	$47.77
$60,000-$69,999	$56.04	$58.12
$70,000-$79,999	$64.38	$66.46
$80,000-$89,999	$76.84	$78.92
$90,000-$99,999	$85.14	$87.23
$100,000-$149,999	$94.37	$96.45
$150,000 and up	$94.37	$96.45

Single + 1 Coverage - Bi-Weekly Costs		
Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$48.52	$52.58
$40,000-$49,999	$65.84	$69.90
$50,000-$59,999	$82.08	$86.14
$60,000-$69,999	$100.11	$104.17
$70,000-$79,999	$116.35	$120.40
$80,000-$89,999	$137.09	$141.15
$90,000-$99,999	$153.33	$157.39
$100,000-$149,999	$170.59	$174.65
$150,000 and up	$177.91	$181.97

Family Coverage - Bi-Weekly Costs		
Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$72.95	$79.06
$40,000-$49,999	$97.27	$103.37
$50,000-$59,999	$121.50	$127.60
$60,000-$69,999	$145.09	$152.00
$70,000-$79,999	$170.22	$176.33
$80,000-$89,999	$206.14	$212.24
$90,000-$99,999	$230.55	$236.66
$100,000-$149,999	$255.33	$261.43
$150,000 and up	$267.49	$273.59

MEDICAL BENEFITS

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MANAGED CHOICE POS (OPEN ACCESS) PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	**Individual:** None **Family:** None	**Individual:** $750 **Family:** $1,875
Out-of-Pocket Maximum	**Individual:** $1,250 **Family:** $2,500	**Individual:** $2,000 **Family:** $5,000
Coinsurance	You pay 0% Aetna pays 100%	You pay 20% Aetna pays 80%
Preventive Care		
Adult Preventive Care	No charge	20% coinsurance*
Adult Annual Physical Exam	No charge	20% coinsurance*
Well-Child Care	No charge	No charge
Inpatient Hospital	$250 copay per admission	20%*
Outpatient Care		
Primary care physician office visits	$25 copay	20% coinsurance*
Specialist office visits	$25 copay	20% coinsurance*
Outpatient facility surgery	No charge	20% coinsurance*
Laboratory and X-ray	No charge	20% coinsurance*
Complex Radiology *(MRIs, MRAs, CT Scans, Pet Scans)*	No charge	20% coinsurance*
Emergency Care		
Ambulance -medically necessary	No charge	20% coinsurance*
At hospital emergency room	$50 copay	$50 copay
Urgent Care	$25 copay	20% coinsurance*
Maternity Care		
Prenatal care	No charge	20% coinsurance*
Hospital services for mother and child	$250 copay per admission	20% coinsurance*
Mental Health/Substance Abuse		
Inpatient	$250 copay per admission	20% coinsurance*
Outpatient	$25 copay	20% coinsurance*
Prescription Drugs		
Retail Pharmacy (30 day supply) Tier-1/Tier-2/Tier-3	$15/$25/$40	20% after copay
Mail Order (90 day supply - 2x retail) Tier-1/Tier-2/Tier-3	$30/$50/$80	20% after copay

*after deductible is met

How to Locate a Network Provider:

To find a dentist that participates in either network, follow these steps:

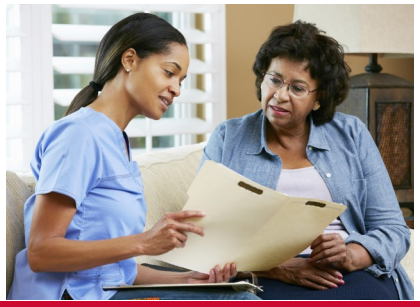
Step 1: Click here to access the search tool
Step 2: Enter your ZIP code or city/state under "continue as guest" and click search. This will allow you to search the entire directory or search for a specific provider.
Step 3: Select a plan choice "Managed Choice POS" and click continue to search for doctor.
Step 4: Search by doctor name or select what you need by category.
Step 5: Click or search for a specific provider type and your list will appear

MOBILE APP

Download the **"Aetna Health"** app from the App Store or Google Play store. With this app you provides access to the following services:

- Access your member ID card
- View benefits & pay claims
- Search for providers, procedures and medications
- Get cost estimates before you get care

And much more…



POS (HIGH) PLAN CONTRIBUTIONS

Single Coverage - Bi-Weekly Costs		
Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$449.42	$451.51
$40,000-$49,999	$458.58	$460.32
$50,000-$59,999	$467.73	$469.91
$60,000-$69,999	$476.88	$478.97
$70,000-$79,999	$486.08	$471.54
$80,000-$89,999	$495.19	$497.27
$90,000-$99,999	$504.34	$506.42
$100,000-$149,999	$513.49	$515.58
$150,000 and up	$513.49	$518.58

Single + 1 Coverage - Bi-Weekly Costs		
Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$875.01	$879.07
$40,000-$49,999	$892.83	$896.89
$50,000-$59,999	$910.65	$914.71
$60,000-$69,999	$928.47	$932.53
$70,000-$79,999	$946.29	$950.36
$80,000-$89,999	$964.11	$968.17
$90,000-$99,999	$981.93	$985.99
$100,000- $149,999	$999.75	$1,003.81
$150,000 and up	$1,003.00	$1,011.06

Family Coverage - Bi-Weekly Costs		
Your Salary	Rate effective 1/1/24 with tobacco-free discount	Rate effective 1/1/24 without tobacco-free discount
$30,000-$39,999	$1,315.67	$1,321.77
$40,000-$49,999	$1,342.46	$1,372.98
$50,000-$59,999	$1,369.26	$1,375.36
$60,000-$69,999	$1,396.05	$1,402.15
$70,000-$79,999	$1,422.84	$1,428.95
$80,000-$89,999	$1,449.64	$1,455.74
$90,000-$99,999	$1,476.43	$1,482.54
$100,000-$149,999	$1,503.23	$1,509.33
$150,000 and up	$1,508.09	$1,516.20

MEDICAL BENEFITS INFORMATION

KNOW BEFORE YOU GO

	CONDITIONS TREATED	YOUR COST & TIME
Emergency Room (ER) For the immediate treatment of critical injuries or illness. If a situation seems life threatening, call 911 or go to the nearest emergency room. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Severe cuts or burns	• Costs are highest • No appointment needed • Wait times may be long, averaging over 4 hours
Urgent Care Center For conditions that are not life threatening. Urgent Care Centers are staffed by nurses and doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Urinary tract infection	• Costs are lower than an ER visit • No appointment needed • Wait times vary
Doctor's Office The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	• General health issues • Preventive services • Routine checkups • Immunizations and screenings	• May include a copay/coinsurance and/or deductible • Appointment usually needed • May have little wait time
Video Conference - TELEDOC Staffed by Board Certified Doctors. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication. With your consent, Teladoc will provide information about your consult to your primary care physician.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Prescriptions	• Costs are same or lower than office visit • Available 24/7 from your smartphone or tablet Just register at Teledoc.com or download the Teledoc mobile app

MEDICAL BENEFITS INFORMATION

TELEDOC

Teladoc is a benefit through Aetna that provides you and your eligible dependents with 24/7/365 access to U.S. board Certified doctors and pediatricians by phone or online video.

HOW IT WORKS

STEP 1: **CONTACT TELADOC 24/7/365** - Access to Teladoc's nationwide network of board-certified physicians is available via phone, video or mobile app.

STEP 2: **TALK WITH A PHYSICIAN** - A physician will review your medical history and contact you within minutes.

STEP 3: **RESOLVE THE ISSUE** - A physician will diagnose and prescribe medication, if medically necessary, electronically to the pharmacy of choice.

ANYTIME, ANYWHERE

Teladoc does not replace your primary care physician. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many of your medical issues.

EXPERIENCE YOU CAN TRUST

Teladoc doctors are U.S. board-certified, licensed in your state and average 15 years of practice experience. With your consent, Teladoc will provide information about your consult to your primary care physician.

Set up an account	Provide medical history	Request a consult
• Visit the Teladoc website and click "Set up account"	• Log in and complete the "My Medical History" tab	• A Teladoc doctor is always just a call or click away

GENERAL MEDICAL

$56 less / visit
Talk to a licensed doctor for non-emergency conditions
Flu • Sinus infections • Sore throats • And more

MENTAL HEALTH

$90 or less / therapist visit
$215 or less / psychiatrist first visit
$100 or less / psychiatrist ongoing visit
Talk to a therapist 7 days a week (7 a.m. to 9 p.m. local time)

DERMATOLOGY

$85 or less / consult
Upload images of a skin issue online and get a custom treatment plan within two days
Eczema • Acne • Rashes • And more

CONTACT TELEDOC
Visit the website at
www.Teladoc.com
or call
800.TELADOC (835.2362)

You can also download the app from Apple App Store or Google Play

MEDICAL BENEFITS INFORMATION

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PHARMACY TOOLS

MANAGING YOUR MEDICINES

Your plan offers:

- Coverage for most medicines
- The convenience of mail service pharmacy
- Personal support for specialty medicine needs
- Your personal member website with tools to help you find what you need fast
- A pharmacy help line you can call 24/7 if you have questions— call **888.792.3862**

HOW TO FIND OUT IF YOUR MEDICINES ARE COVERED AND WHAT THEY'LL COST

Before you enroll:
In your plan materials, you can see what medicines are covered and how much they'll cost. You can also visit Aetna.com/formulary and choose your plan name to find covered medicines and alternatives that cost less. Don't see it, or need your plan name? Just ask your employer.

After you enroll:
Visit Aetna.com to register and sign in to your member website. There, you can estimate your costs and compare what you'd pay through your local pharmacies versus mail service.

WHAT IS PREAUTHORIZATION?

Some medicines your doctor prescribes may need preauthorization. This means they need approval before they can be covered. Or we may ask your doctor to prescribe a lower-cost version. If needed, you or your doctor can always ask for an exception.

Where can I get my medicines?
Retail pharmacy — occasional prescriptions
For medicines like antibiotics that you take short term, you can visit any retail pharmacy — whether you're at home or on the go. For the best price, choose a network pharmacy on Aetna.com.

CVS Caremark® Mail Service Pharmacy
Long-term prescriptions - You can use this service for medicines you need to take for conditions like high blood pressure or diabetes. Your medicines are mailed to you quickly and safely at no extra charge. And you may get up to a 90-day supply.
Specialty pharmacy — long-term special medicines
Some long-term health conditions, like multiple sclerosis or cancer, require special medicines. You can also get extra help to learn how to manage side effects.

MEDICAL BENEFITS INFORMATION

aetna

AETNA® BEHAVIORAL HEALTH ABLETO SUPPORT

Here for you when you need it

MANAGE LIFE'S CHANGES

Some life events can be overwhelming. Like having a baby. Or finding out you have diabetes or heart disease.
You may also feel emotions like:

- Worry
- Depression
- Confusion
- Anger

All of these feelings are normal. But they can make it harder for you to take control and make healthy changes. And it's important to feel you can control the health condition or life change, instead of it controlling you.

REAL HELP THAT FITS YOUR SCHEDULE

The **AbleTo** program can help you:

- Work through these normal emotions
- Understand and stick with your treatment plan
- Know the types of changes you need to make
- Feel like you are in control of your health and your life

AbleTo is part of your Aetna membership. But it's not like traditional programs. It makes it easy to get the help you need.

SUPPORT WHEN AND WHERE YOU NEED IT

We've teamed up with **AbleTo**, a leading behavioral health care provider, to offer this convenient program.

The goal is to make it easy for you to complete the program. And to help you see that you are in control and can make healthy changes.

REAL HELP THAT WORKS

Meet face-to-face with a therapist and behavior coach using online video. Or you can simply talk on the phone, if you prefer.

This removes the time and hassle of driving to appointments.
Plus, you choose the times that work best for you. During the day, in the evening or on weekends.

YOU'LL WORK WITH TWO ABLETO SPECIALISTS FOR EIGHT WEEKS

Once a week with a therapist to address emotional challenges like depression, stress and anxiety that can come with a medical diagnosis

Once a week with a behavior coach to identify health goals and develop an action plan

That's two sessions a week, including a final meeting with your therapist. And it's all part of your Aetna membership.

CONSIDER ABLETO SUPPORT IF YOU HAVE EXPERIENCED ONE OF THESE HEALTH CONDITIONS OR LIFE CHANGES:

- Infertility
- Breast or prostate cancer recovery
- Heart issues
- Diabetes
- Digestive health issues
- Pain management
- Breathing problems
- Alcohol or substance use disorder
- Depression, anxiety or panic
- Postpartum depression
- Caregiving stress (child, elder or autism)
- Grief and loss
- Military transitions

CONVENIENT EIGHT-WEEK PROGRAM

with counseling and coaching by video or phone.
Just call **AbleTo** at 844.330.3648.

IT'S EASY TO GET STARTED

If your claims data shows you would benefit from this program, an Aetna or **AbleTo** representative will call you to explain how it works and how it can help you. In most cases, there is no cost to you.

You'll be asked to confirm some information for privacy purposes.

CONTACT ABLETO

Visit the website at:
www.Ableto.com
or call
844.330.3648
Monday - Friday / 9 AM - 8 PM ET

DENTAL BENEFITS

aetna

AETNA DENTAL PPO PLAN

Under this plan you are not required to select a Primary Care Dentist. You have the option of seeing any provider within the Aetna Network or you can use a non-network dentist. In-network benefits dentists however are reimbursed on an agreed upon fee schedule.

Out-of-network dentists are reimbursed at 90% of usual and customary charges, however, any charges beyond that schedule are the patient's responsibility.

For more information about the Aetna dental plan, or to search for participating dentists, please visit www.aetna.com.

How to Locate a Network Provider:

To find a dentist that participates in either network, follow these steps:

Step 1: Click here to access the search tool
Step 2: Enter your ZIP code or city/state and click search. This will allow you to search the entire directory or search for a specific dentist.
Step 3: Select a plan choice "Dental PPO" and click continue to search for dentist.
Step 4: Search by dentist name or select "Dental Care." If selecting "Dental Care," you can search by primary care, pediatric dentists, orthodontists, oral surgeons, and more.
Step 5: Click or search for a specific provider type and your list will appear.

PASSIVE PPO WITH PPOII NETWORK

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (Calendar Year)	**Individual:** $100 **Family:** $300	**Individual:** $100 **Family:** $300
Annual Benefit Maximum (Calendar Year)	$2,500	$2,500
Out-of-Network Reimbursement	N/A	90th percentile of UCR
Diagnostic & Preventive Services Prophylaxis (Cleanings); Oral Examinations; Fluoride; Bitewing Images; Full month series images; Sealants (permanent molars only); Space Maintainers	100%	100%
Basic Services Root canal therapy; Scaling and root planning; gingivectomy; Amalgam (silver) filings; Composite filings; Stainless steel crowns; Incision and drainage of abscess; Surgical removal of teeth; General anesthesia	80% after deductible	80% after deductible
Major Services Inlays; Onlays; Crowns, Full & partial dentures; Pontics; Denture repairs; Crown build-ups	50% after deductible	50% after deductible
Orthodontic Services (children only; appliance must be place prior to age 20 Lifetime Benefit Maximum	50% coinsurance (deductible waived) $1,000	50% coinsurance (deductible waived) $1,000

Cost - Employee dental contributions will continue to be deducted from your pay on a pre-tax basis, as outline below.

Bi-Weekly Contributions	
Employee Only	**$8.26**
Employee + 1	**$17.85**
Employee + Family	**$27.83**

VISION BENEFITS

EYEMED VISION PLAN

EyeMed offers a low-cost, comprehensive vision plan with a network of both independent providers and retail chains. In-network coverage includes a $10 eye exam, lenses/contacts every 12 months and frames every 24 months.

For more information about the EyeMed Vision plan or to search for participating providers, please visit the EyeMed Site at www.eyemedvisioncare.com.

SELECT NETWORK VISION PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10 copay	Up to $35 reimbursement
Hardware (Frames and Lenses)	$25 copay	See Below
Frames	$120 allowance; 20% off balance over $120	Up to $48 reimbursement
Lenses		
Single Vision Lenses	$25 copay	Up to $25 reimbursement
Bifocal Vision Lenses	$25 copay	Up to $40 reimbursement
Trifocal Vision Lenses	$25 copay	Up to $60 reimbursement
Standard Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40 reimbursement
Premium Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40 reimbursement
Frequency		
Exam	Once everyone 12 months	Once everyone 12 months
Lenses	Once everyone 12 months	Once everyone 12 months
Frames	Once everyone 24 months	Once everyone 24 months
Contact Lenses		
Standard Fit & Follow-up	Up to $40	N/A
Conventional	$135 allowance, 15% off balance over $135	Up to $95 reimbursement
Disposable	$135 allowance; 15% off balance over $135	Up to $95 reimbursement
Medically Necessary	$0 copay; paid in full	Up to $200 reimbursement
Cost - Employee vision contributions will continue to be deducted from your pay on a pre-tax basis, as outline below.		
Bi-Weekly Contributions		
Employee Only	**$2.77**	
Employee + 1	**$5.26**	
Employee + Family	**$7.72**	

HOW TO FIND A VISION PROVIDER

Step 1: Log on to www.eyemed.com

Step 2: Click on "**Find an eye doctor"** at the top of the page

Step 3: Enter the area you want to search i.e. City & State or Zip Code or click on **"Use My Location"**

Step 4: Click on the **"Choose Network"** dropdown menu and click on **"Select Network"**

Step 5: Click on **"Get Results"** or click on **"Advanced Search"** and enter your search criteria then click **"Get Results"**

MOBILE APP

Download the **"EyeMed Member"** app from the iTunes app or Google Play store. With this app provides access to the following services:

- Electronic ID card for office visits
- Find nearby network providers
- Appointment scheduling
- View benefit plan details
- Save vision prescriptions
- Eye exam and contact lens reminders

And much more…

HSA & HRA BENEFITS INFORMATION

PAYFLEX®

BRi Benefit Resource Inc.

HEALTH SAVINGS ACCOUNT – ADMINISTERED BY PAYFLEX

- By selecting the **High Deductible Health Plan** option, most employees, except those enrolled in Medicare, would qualify to open a Health Savings Account (HSA).
- All funds you contribute into your HSA are deducted on a pre-tax basis and there is no use it or lose it penalty. In addition, funds roll-over from year-to-year and you can take the money with you when you leave College employment.
- In January 2024, the College will contribute 33% of the cost of your HDHP deductible into your Health Savings Account. The College's contribution to your Health Savings Account is yours to keep even if you do not spend it and/or if you leave the College.
- HSA payments for qualified medical/dental/vision expenses will be administered by Aetna's provider, PayFlex, who will issue you a card that you can use to pay providers and for prescriptions.
- New enrollees eligible for this benefit must complete an HSA Enrollment form. For current HSA enrollees, please note that HSA elections are not restricted to the annual open enrollment period and are instead managed month-to-month throughout the year. This means you can change your election as of the first pay date of any month.

HEALTH REIMBURSEMENT ACCOUNT – ADMINISTERED BY BRI

- Because Medicare enrolled employees are not permitted to open an HSA, the College will continue to offer these employees the ability to enroll in a Health Reimbursement Account (HRA) to use in conjunction with the High Deductible Health Plan.
- Eligibility to participate in an HRA is based on enrollment in the Aetna HDHP and not being eligible to participate in an HSA due to being enrolled in Medicare Part A. HRA plans however are limited to the College's contributions. Therefore, these employees may instead contribute pre-tax dollars to a Flexible Spending Account.
- In January 2024, the College will contribute 33% of the cost of your HDHP deductible into your HRA. Please note that the College's contributions to the HRA revert back to the College should the employee leave College employment for any reason. However, as long as the employee continues to be employed by the College, remaining HRA funds roll-over from year-to-year.
- HRA participants submit their qualified medical/dental/vision through Benefit Resources Inc. ("BRI"), who is also the College's FSA and commuter plan benefits administrator. BRI will issue you a card, which you can use to pay providers and pay for prescriptions. New enrollees eligible for this benefit must complete an HRA enrollment form. Current enrollees need not fill out new forms.

FSA BENEFITS INFORMATION

FLEXIBLE SPENDING ACCOUNTS – ADMINISTERED BY BRI

For those who are unfamiliar with this benefit, a Flexible Spending Account provides you a way to pay for eligible health-related expenses such as deductibles, copayments, and coinsurance on a pre-tax basis through payroll deductions. For the 2024 plan year, the College will continue to offer two separate FSA options. Please see highlights of each plan below.

Please note that employees cannot have a Health Savings Account (HSA) and a General Purpose Health Care Flexible Spending Account (FSA) at the same time. Therefore, employees enrolled in a Flexible Spending Account in 2023 must use all of their FSA money prior to January 1, 2024 or they cannot contribute to a Health Savings Account.

Medicare enrollees who elect the HDHP may continue to contribute pre-tax dollars to a General Purpose Health Care Flexible Spending Account.

Flexible Spending Account

- The Flexible Spending Account maximum for 2024 is **$3,200**. Elections made for January 1, 2024 cannot be changed during the year.
- Election for this benefit must be made by completing the FSA enrollment form. **Please note that you cannot elect this benefit for 2024 if you enroll in a Health Savings Account.**

Limited Purpose" Flexible Spending Account ("LP-FSA")

- A Limited Purpose FSA is offered to those employees with a Health Savings Account who are seeking additional pre-tax benefits. **This account restricts the payment of plan expenses to certain vision and/or dental expenses**.
- The Limited Purpose Flexible Spending Account maximum for 2024 is **$3,200**. Elections made for January 1, 2024 cannot be changed during the year.
- Election for this benefit must be made by completing the FSA enrollment form. Please note that you can elect this benefit for 2024 even if you enroll in a Health Savings Account.

If you are currently enrolled in the FSA or LP-FSA for the plan year 2023, the plans include a $610 "rollover benefit". This means that employees with $610 or less in their account at the end of the 2023 calendar year can roll these funds over into the 2024 plan year. **However, any remaining funds over $610 after the run out period ending on February 28, 2024 would be forfeited.** For the plan year 2024, the plans include a $640 "rollover benefit".

CBP & SRA BENEFITS

PRE AND POST COMMUTER BENEFITS (TRANSIT AND PARKING) – ADMINISTERED BY BRI

The College will continue our Transit and Parking commuter programs with BRI in 2024. These accounts allow eligible employees to either pay for mass transit or parking expenses on a pre and post-tax basis.

Please note that elections for commuter benefits are not restricted to the open enrollment period and are instead managed month-to-month throughout the year. This means you can change your election as of the first pay date of any month.

Elections for these benefits must be made by completing the BRI Commuter Benefits enrollment form, which can be used to

COMMUTER BENEFITS PLAN LIMITS	2024
Qualified Transit Pre-tax Monthly Limit	$315
Qualified Parking Pre-tax Monthly Limit	$315

SUPPLEMENTAL RETIREMENT ACCOUNT – ADMINISTERED BY TIAA

Upon employment at St. Francis College, all employees are eligible to open and make pre-tax contributions to a Supplemental Retirement Account through TIAA-CREF. SRA accounts are employee-contributed and there is no age restriction on an employee's ability to make pre-tax contributions from their salary.

Please note that elections for the SRA are not restricted to the open enrollment period and are instead managed month-to-month throughout the year. This means you can change your election as of the first pay date of any month.

SUPPLEMENT RETIREMENT PLAN LIMITS	2024
Annual Contribution Limit	$23,000
Annual Contribution Limit for those age 50 or older - $7,500	$30,500

SUPPLEMENTAL LIFE

SUPPLEMENTAL LIFE INSURANCE - ADMINISTERED BY MUTUAL OF OMAHA EFFECTIVE JANUARY 1, 2024

If you did not previously elect the Supplemental Life benefit you still have the opportunity to enroll but will need to complete an evidence of insurability questionnaire. Mutual of Omaha will review the questionnaire and make a decision to approve or deny your coverage request based on your answers.

Here are some important points to know about our Supplemental Life benefit through Mutual of Omaha:

- You may purchase Supplemental Life in increments of $10,000;
- Premiums are automatically deducted from your paycheck on a post-tax basis;
- The maximum amount you can purchase cannot be more than $500,000 or 3x your annual salary;
- Costs are calculated based on an employee's age, as detailed below;
- Supplemental life benefits reduce by 35% when you attain ages 65, 70, 75 and further reduce by 25% when you attain ages 80, 85, 90, 95. All coverage cancels at retirement.

To calculate how much supplemental life insurance would cost for you, please use the rate chart below with the following formula:

Age	Under 25	25-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.04	$0.04	$0.06	$0.09	$0.15	$0.26	$0.43	$0.57	$0.90	$1.57	$2.70

With the offering of this benefit, you can also elect Spouse Supplemental Life Insurance, but the amount you purchase must be the lesser of $100,000 or 50% of the amount of supplemental life insurance that you elect for yourself. The rates are the same as above and based on your age, however, spouse supplemental life is purchased in $5,000 increments and will require your spouse to complete an evidence of insurability questionnaire.

Finally, if you elect supplemental life for yourself, you may also purchase supplemental life insurance for your child(ren) who are within the ages of 15 days and 19 years (25 years if a full time student), in the amount of $10,000. The monthly cost is a fixed rate of $0.40/month, covering all children.

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

Mutual of Omaha's Employee Assistance Program (EAP) assists employees and their eligible dependents with personal and job-related concerns, including:

- Emotional Well-being
- Family and relationships
- Legal and Financial
- Healthy lifestyles
- Work and life transitions

EAP Benefits

As an employee, or eligible dependent, of St. Francis College your EAP benefits include:

- Access to EAP professionals 24 hours a day, seven days a week
- Information and referral services
- Service for employees and eligible dependents
- Robust network of licensed and /or certified mental health professionals
- Three face to face sessions with a counselor (per household per calendar year)

Legal and financial resources

- Online will preparation
- Legal library and online forms
- Financial tools & resources

Resources for:

- Work/life balance
- Substance use
- Dependent and Elder Care resources
- Access to a library of educational articles,
- handouts and resources via
- as a dependent as defined in the Internal Revenue Code.

Your EAP benefits are provided through your employer. There is no cost to you for utilizing EAP services. If additional resources are needed, your EAP professional can assist by locating affordable solutions in your area.

Mutual of Omaha's Employee Assistance Program provides professional, confidential quality consultation, 24 hours a day.

Visit:

mutualofomaha.com/EAP

Call: 800.316.2796

ADDITONAL BENEFITS

ADDITONAL BENEFITS OFFERED BY MUTUAL OF OMAHA AT NO COST

LEGAL DOCUMENT PREPARATION

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Easy, Free and Secure

As an employee of St Francis you are eligible for this service. Epoq, Inc., Mutual of Omaha's provider, offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

The following FREE documents are provided:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

Log on to **www.willprepservices.com** and use the code MUTUALWILLS to register

- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child

FAQ– HEALTH SAVINGS ACCOUNT (HSA)

GENERAL QUESTIONS

Q: Why would someone choose a High Deductible Health Plan (HDHP) with a Health Savings Account (H.S.A.) over a traditional Aetna Point-of-Service (POS)?

A: There may be several reasons:

1. Reduced Payroll deductions – please take note that the bi-weekly cost of coverage is considerably less in a H.S.A. vs. the POS medical plan options.
2. Tax advantages – Federal, Social Security, and State taxes are not payable on voluntary H.S.A. contributions. Taxes are also not payable when H.S.A. monies are withdrawn as long as they are used for qualified health expenses.
3. Not only are H.S.A. contributions tax free going into the Plan and coming out of the Plan, but any interest or investment earnings are tax free too.
4. Employees do not receive retiree medical coverage. Even those with retiree medical coverage will likely incur significant expenses and premiums. H.S.A. accounts are an excellent way to tax-efficiently fund future retirement medical expenses.

Q: How can I find a list of eligible medical expenses for which I can use my H.S.A. account to pay?

A: This plan is regulated by the IRS and a list has been published under section 213(d). It is a similar list to the expenses listed under the Healthcare FSA.

Q: I noticed that there is a single and family deductible but no separate amounts for "employee plus one dependent". How come?

A: These are the classifications set forth by the IRS.

Q: Will my Health Savings Account (H.S.A.) provisions, such as deductibles, co-insurance and annual out-of-pocket maximum's change? What about the limits imposed on annual H.S.A. contributions made by me?

A: The deductibles, coinsurance, annual out-of-pocket maximums are subject to change annually due to IRS guidance changes and your employer's discretion. The H.S.A. contribution limits are determined by the IRS

ELIGIBILITY

Q: Are my family members also covered by the H.S.A. account? Is this linked to their participation in the HDHP?

A: Yes, you may withdraw funds to pay for the qualified medical expenses of yourself, your spouse or a dependent without tax penalty. This is one of the great advantages of HSAs. Members do not have to be on the medical plan but they have to be a spouse or tax dependent to use the dollars in the HSA for withdrawals.

Q: Who cannot join a HDHP/H.S.A.?

A: Anyone who (1) participates in a Health Care FSA or a spouse's FSA, (2) is covered by a non HDHP medical plan, (3) is covered under TRICARE or TRICARE for life, (4) has used VA benefits in the past 3 months or (5) enrolled in Medicare (A, B or D).

Q: Must my family be covered under my HDHP in order for me to spend H.S.A. dollars toward their eligible medical expenses?

A: You can access H.S.A. monies for reimbursement of family members expenses whether they participate in the HDHP or not. The amount you can contribute is tied to your medical coverage.

FAQ– HEALTH SAVINGS ACCOUNT (HSA)

Q: What if I am enrolled in the Aetna HDHP plan and my spouse is enrolled in Medicare. Will this impact my ability to open an H.S.A. or pay for our qualified healthcare expenses?

A: No. Each H.S.A. owner's eligibility is determined separately, so as an eligible employee you can still open up an H.S.A. account. Once an H.S.A. is established by an H.S.A.-eligible individual, H.S.A. funds can be used to reimburse qualified expenses, even those incurred by dependents who are not H.S.A.-eligible themselves. As long as the employee themselves is eligible to contribute/receive contributions to an H.S.A. for each month they make or receive contributions, the fact that their dependents are not eligible to establish or contribute to/receive contributions to their own H.S.A.'s is immaterial.

Q: What if my spouse also has an HDHP plan. Can both of us participate in an H.S.A.?

A: If both spouses have self-only coverage, they are eligible to contribute to an H.S.A. up to $3,450 each. If both Spouses have Family Coverage they can only contribute the Family contribution amount between the two accounts. They may also contribute the catch up contribution if eligible.

MID-YEAR ENROLLMENT

Q: How is my HSA funded if the effective date of my HDHP coverage is not January 1st?

A: Employees who enroll in the HDHP after January 1 of each year will receive a pro-rated College contribution based on the number of full months during the calendar year in which they are enrolled in the H.S.A plan. However, employees who enroll in the HDHP on or after November 1st in any calendar year will not receive an H.S.A contribution from the College.

Q: How is my HSA funded during the calendar year if I experience a qualifying event, e.g., request to add a new spouse or new dependent to my HDHP coverage during the year?

A: For employees who experience a qualifying event to add an individual(s) during a calendar year, upon submission of the appropriate documentation, the College will make an additional H.S.A contribution on your behalf, however, the contribution will be pro-rated based on the number of full months during the calendar year you and your added spouse/dependent are enrolled in the H.S.A.

MY H.S.A. ACCOUNT

Q: Can I contribute to an H.S.A. via personal contribution more than what I specify via bi-weekly contributions?
A: Yes, although the combined contribution cannot exceed the IRS maximums.
Q: Can I enroll in the HDHP/H.S.A. and then go back to the traditional medical plan during a subsequent annual open enrollment? A: Yes.
Q: Can I select a Flexible Spending Account (FSA) with a High Deductible Health Plan with an H.S.A.?

A: Yes, as long as it is a "Limited Purpose Health FSA". Only out-of-pocket dental and vision expenses would be reimbursable.

Q: How does the deductible work if I am enrolled in the Family Plan?

A: Under the Family Plan, there is no "single deductible limit". One individual can satisfy the entire deductible for The family. Collectively, the Family must have $6,000 in deductible eligible expenses to satisfy the Family deductible.

FAQ– HEALTH SAVINGS ACCOUNT (HSA)

MY H.S.A. ACCOUNT - *continued*

Q: Am I eligible for the H.S.A. catch-up contributions? What is the catch up limit? Will payroll facilitate catch-up contributions?

A: Individuals age 55 and older are eligible to contribution up to $1,000 in catch up contributions each year. This will be facilitated through payroll once you have made your elections.

Q: Is my H.S.A. account portable?

A: Yes. Upon employment termination you can take your H.S.A. with you.

Q: I am a new hire, can I contribute the annual H.S.A. maximum even if I'm hired in November for instance?

A: Yes. You may risk additional tax penalties however, if you fail to remain an eligible participant for 12 months after the year in which you first become eligible.

Q: Are H.S.A. rollovers into the plan accepted?

A: Yes, you can rollover previous H.S.A. funds as long as the rollover is received within 60 days of the receipt of the rollover. You are allowed one rollover per year.

Q: Are H.S.A. rollover transfers out of the St. Francis plan accepted upon employment termination?

A: Yes, however you must comply with the rollover provisions as stated above.

Q: Do I get interest on my H.S.A. account or can I invest the money in the market?

A: Your H.S.A. account is much like an IRA account. You can choose from a list of investments and will be eligible to receive interest based off of your investment choices. A floating interest rate is used that reflects the rate credited to their preferred money market accounts. The interest rate is applied to daily balances in the account, compounded monthly and credited by the second banking day following the end of the month. You can also access investment options once you have accumulated more than $1,000 in the H.S.A. fund.

Q: Can I roll IRA money to an H.S.A.?

A: You may make a one-time transfer from your IRA into your H.S.A., but you will reduce your H.S.A. contributions for that year. If you do not remain as an eligible participant for 12 months after the month of transfer, you may face up to 20% in additional taxes.

FAQ– HEALTH SAVINGS ACCOUNT (HSA)

Q: In the event of my death, if I am married, what happens to my H.S.A.?

A: If you are married, upon death the remaining funds would be transferred to your spouse.

Q: In the event of my death, what becomes of my H.S.A. paid out to my designated non-spouse beneficiary?

A: The funds would be designated as taxable income.

Q: In the event of divorce (with or without a Qualified Domestic Relations Order -QDRO) what happens to my H.S.A. account?

A: The account follows the direction of the divorce decree.

Q: Must I report H.S.A. activity to the I.R.S.?

A: Payroll reports annual H.S.A. contributions (both employer and employee) in box 12 of your W2. Tax forms will be provided by ADP by January 31st . Participants will complete Form 8889 as part of their tax return filing. This form reflects contributions made to the account and distributions received from the H.S.A. account. The H.S.A. bank will also report account activity to the IRS on forms 1099SA and 5498 SA. You will receive copies of these as well.

USING MY HSA ACCOUNT

Q: How do I access the monies in my H.S.A. account?

A: H.S.A. funds can be accessed by using a debit card, online bill payment, ATM cash withdrawal or optional checks.

Q: What types of premiums can I pay for with H.S.A. funds?

A: You may only use your H.S.A. to pay for health care premiums if you are collecting Federal or State Unemployment, or you are enrolled in COBRA through a former employer. Once you have reached age 65 you can also use the funds to pay for Medicare Premiums (excluding MediGap) or Long Term Care premiums.

Q: Must I use my H.S.A. account when I incur HDHP out-of- pocket expenses? Can I pay with cash and preserve the ongoing tax free growth of my H.S.A. account?

A: You may use your H.S.A. funds now or save for future expenses. If you choose this option, you will need to pay incurred expenses through another payment source other than your H.S.A.

Q: Can I use my H.S.A. account for non-qualified medical expenses?

A: Non-qualified medical expenses are viewed as income and therefore subject to income taxes as well as a 20% penalty.

Q: If I run out of H.S.A. money can I change my contribution level at any time?

A: Yes, contributions can be changed on the first pay date of any month during the year.

FAQ– HEALTH SAVINGS ACCOUNT (HSA)

COBRA

Q: Can participants continue to contribute to an H.S.A. while enrolled in COBRA? What if they are no longer working and don't have the facility of payroll deductions?

A: A COBRA participant can contribute to an H.S.A. The contribution deduction will be reported on their personal income tax return.

ADMINIATRATION & FEES

Q: Who administers the HDHP?

A: Aetna

Q: Who administers the H.S.A. banking account?

A: Aetna through Payflex.

Q: Who pays the H.S.A. banking and investment fees?

A: You will be responsible for any banking fees associated with the H.S.A. account. These fees are similar in nature to what you would be traditionally charged for a traditional checking account.

CONTACTS

St. Francis College Office of Human Resources		HR@sfc.edu
Nicole Hall, Executive Director of Human Resources	718.522.2300	nicolehall@sfc.edu
Kennie Allahar, Human Resources Generalist	718.489.5349	kallahar@sfc.edu
Aetna Medical • Member Services • Informed Health Line • Pharmacy Management • Prescription Home Delivery	 800.962.6842 800.556.1555 888.792.3862 800.227.5720	www.aetna.com
PayFlex HSA	844.PAYFLEX 844.729.3539	www.payflex.com
Aetna Dental	877.238.6200	www.aetna.com
EyeMed Vision Care	866.723.0513	www.eyemedvisioncare.com
Benefit Resource Inc. (BRI) • FSA • Commuter Benefit Program (Parking/Transit) • HRA Benefits	800.473.9595	www.benefitresource.com www.briweb.com
Mutual of Omaha • General Services • Life Claims • Disability Claims– Faculty • Life Conversion • Life & Long-Term Disability Portability • Travel Assistance • Maxon Disability Claims– Non-Faculty Staff • Paid Family Leave & DBL	 800.769.7159 800.775.8805 **Fax:** 402.997.1995 800.877.5176 800.826.8054 877.466.8367 800.856.9947 800.999.3309	www.mutualofomaha.com newyorkservice@mutualofomaha.com
Mutual of Omaha - Employee Assistance Program	800.316.2796	www.mutualofomaha.com/eap
TIAA-CREF	800.842.2252	**SFC Microsite** Enroll.tiaa-cref.org/stfranciscollege
BenefitsVIP	866.293.9736	www.solutions@benefitsvip.com www.benefitsvip.com

ANNUAL HEALTH NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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, 2022. Contact your State for more information on eligibility –

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

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

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program 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+)
Health First Colorado Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

ANNUAL HEALTH NOTICES

All other Medicaid

Website: https://www.in.gov/medicaid/

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

https://www.maine.gov/dhhs/ofi/applications-forms

Phone: -800-977-6740.

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840

TTY: (617) 886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/

dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx

http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/

CHIP Website: http://health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select

https://www.coverva.org/en/hipp

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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)

ST FRANCIS COLLEGE EST. 1859

2024 BENEFITS GUIDE

Your Benefits. Your Choices. Your Health.

This benefit summary provides selected highlights of the employee benefits program available. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Our company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

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