2023

TEAM MEMBER BENEFITS

KING'S DAUGHTERS

What's changing for 2023?

Medical

King's Daughters will continue to offer two medical plans in 2023: the Blue Plan and the White Plan. You will want to take note of the plan features and changes noted below:

Blue Plan

- The Blue Plan is a deductible plan that includes copays for office visits, emergency care and hospital stays
  - There will be a minimal increase to the deductibles for both the KDMC Facility Network and Aetna Network
- The Aetna Network Primary and Specialty care copays will increase slightly
- King's Daughters will continue to pay team member's telemedicine behavioral health copays through 2023

White Plan

- The White Plan is a Qualified High Deductible Health Plan
  - There will be a minimal increase to the deductibles for 2023
  - The deductible, **which applies to all services and prescriptions**, will need to be met before the coinsurance applies
- This plan can be paired with a Health Savings Account (HSA) through WEX, which provides significant tax advantages

Optional Dependent Life

We heard your requests and are pleased to offer new options for higher coverage limits for your spouse and child(ren) for 2023. You have the choice to continue your current dependent life coverage or make the move to the increased benefits. Please review the new options available to you on page 36.

Hospital Indemnity

Our Hospital Indemnity through MetLife has been enhanced to include coverage for behavioral health services. Please review the plan summary detailed in Supplemental Health Benefits section on page 30.

Medical Transportation Services Benefit

The Medical Transportation Service benefit through MASA has been enhanced to include coverage for emergency air ambulance, emergency ground ambulance, hospital to hospital ambulance and repatriation to a hospital near home. The cost will now be $6.47 per pay period. You can find more information on the program in the additional benefits section on page 44.

Texting

Opt in to receive text messages about your benefits! Not at a computer? Receive important messages about your benefits, deadlines, and reminders via text message. Have you added your mobile phone number in your Profile, under the MyBenefits portal, but you have not yet opted into texting?

It's simple to opt in to receive text messages:

- Log into your MyBenefits portal
- On the Home page click the Profile link
- Next to Contact Preferences, click edit
- Review/update your mobile phone number
- Check the Opt Into Text box
- Click Save and you're done!

Table of Contents

Working together is what makes King's Daughters a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This guide offers details on your 2023 benefits. Contact the Human Resources department with any questions.

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Username:
kdmc\team member ID number

Password:
same password utilized to clock in

See **page 48** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Ashland Hospital Corporation dba King's Daughters Medical Center. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility and Enrollment

You're a valued team member of King's Daughters, and your health and well-being are important to us. We are proud to provide you and your dependents with valuable and significant benefits. This guide is an overview of the benefits available to you and their impact on your hard-earned compensation. Please read it carefully in order to make the best choices for you and your family in the 2023 plan year and consult your Human Resources representative with any questions.

You and your family have unique needs, which is why King's Daughters offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

Team members who are in a regular full-time or part-time status are eligible to participate in medical, dental, vision, life and many other voluntary benefits. The elections you make, are effective January 1, 2023, and can only be changed if you have a Qualifying Life Event (QLE).

Coverage Dates

Your elections are effective the first of the month after one month of employment. Benefits cannot be changed until the next enrollment period unless you experience a qualifying life event.

Dependents

Dependents eligible for coverage include:

- Your legal spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, and children for whom legal guardianship has been awarded to you or your spouse) are eligible to remain on medical, critical illness, accident protection, and vision without a full-time student verification.
- Children up to age 23 (includes birth children, stepchildren, legally adopted children, and children for whom legal guardianship has been awarded to you or your spouse) are eligible to remain on dental and/or dependent life without a full-time student verification.
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment.

Working Spouse Exclusion

If your spouse has access to healthcare coverage through their employer, they are not eligible to participate in the King's Daughters health plan. If your spouse does not work, is not eligible for an employer's health coverage, or is an active team member with King's Daughters, this exclusion does not apply. A Spousal Eligibility Request form will be required for a spouse who is not eligible or whose employer does not provide health coverage. The appropriate Spousal Medical Eligibility form will be sent to your King's Daughters work email semi-annually for completion based upon your spouse's employment status. **Any changes to a spouse's eligibility during plan year 2023 are to be reported to Human Resources.**

Note: The Company reserves the right to verify whether or not your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you reported during Open Enrollment. **Misrepresenting whether your spouse has access to medical coverage may result in disciplinary action, up to termination of employment.**

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 23rd or 26th birthday this year? If so, they are no longer eligible for benefits as previously outlined. Additional details can be found in the Eligible Dependents section of this guide.

Note

Open Enrollment is your annual opportunity to make any benefit changes to be effective January 1st unless you have a qualifying life event, such as marriage or the birth/adoption of a child.

Now's the Time to Enroll!

What are **Qualifying Life Events?**

You can update your benefits when you start a new job or during Open Enrollment. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

Common QLEs include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Taking an unpaid leave of absence
- Entitlement to Medicare or Medicaid

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to King's Daughters' Human Resources with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

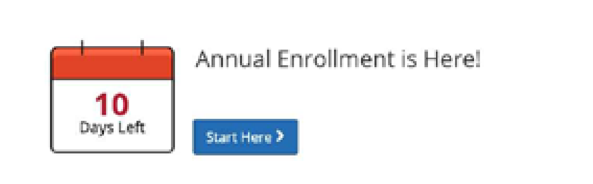
Enroll in your benefits

LOGIN

Visit www.kdhsbenefits.com and login with your kdmc\Team Member ID# and password.

Remember the password is the same as you use for online paystub and API timekeeping.

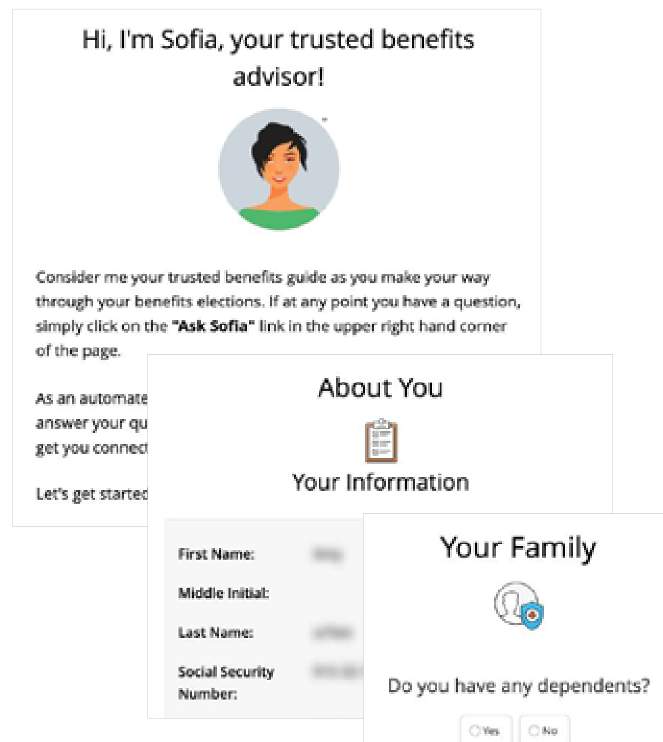
If you don't remember this password, please contact the IST Help Desk at (606) 408-4357 for assistance.



EXPLORE YOUR OPTIONS

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

The calendar at the top of the **Home** page lets you know how many days you have to enroll.



START YOUR ENROLLMENT

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.*

Sofia, your personal benefits assistant, can answer questions and guide you as you enroll.

*You will be required to provide documentation to prove your relationship to each dependent.

Questions? 606-408-0022
www.kdhsbenefits.com

Ready for Open Enrollment?

King's Daughters covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Team Member contributions vary depending on the level of coverage you select — typically, the more coverage you have, the higher your portion.

You can choose any combination of medical, dental, and/or vision coverage. You could select medical coverage for yourself, but dental and vision coverage for yourself and your entire family. The only requirement is that as an eligible team member of King's Daughters, you must elect coverage for yourself in order to elect coverage for dependents.

Open Enrollment Action Items

Update your personal information.

If you've experienced any life changes since the last Open Enrollment period — such as the birth of a child or a move — you may need to change your elections or update your pertinent details.

Double-check covered medications.

If you make any changes to your plan, consider how it affects your prescriptions.

Review available plans' deductibles.

Foresee a lot of medical needs this year? You might want a lower deductible. If not, you could switch to the White Plan and enjoy the advantages of a Health Savings Account (HSA) paired with your High Deductible Health Plan (HDHP).

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.

Utilizing King's Daughters providers and facilities will always save you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best option.

It's never too late to better your wellness. King's Daughters is here to help. This health-management benefit is included for all benefit-eligible team members and is completely confidential.

Tobacco User Surcharge

Quitting is more than an ending — it's a fresh start! We want to support your quitting journey and save you money. King's Daughters has a tobacco user surcharge to help control team member medical premium costs. This surcharge applies to any team member and/or spouse enrolled in the medical plan who are users of tobacco. Team members will be required to complete attestation during open enrollment process that they (and spouse if applicable) are not users of tobacco. **If you do not complete the Tobacco Attestation, you will automatically receive the additional tobacco user surcharge of $62.31 per pay period.** KDMC will perform random cotinine testing throughout the year on team members who have attested they do not use tobacco. Any team member who tests positive for cotinine during a random test who has not completed one of the designated tobacco cessation program alternatives will be subject to disciplinary action, up to and including termination.

Need help quitting? We've got you! King's Daughters provides tobacco cessation support through Aetna, which includes personal coaching, online tools, an audio health library, and discounts on wellness-related products and services.

If you currently don't meet the tobacco-free requirement but you're trying to quit, you may be eligible to avoid the surcharge. Contact Human Resources at 606-408-0022 to complete or enroll in a tobacco cessation program or to submit confirmation of being under a physician's care for tobacco or nicotine use.

Note

Quitting smoking improves your health and quality of life and can even add as much as 10 years to your life expectancy! (Source: CDC)

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Mental Health and Your Medical Plan

In addition to King's Daughters EAP services, the medical plan covers behavioral and mental health services. See plan documents for specifics on coverage for inpatient and outpatient services. Telemental health services are also available through Teladoc.

An important aspect of your overall wellbeing is emotional wellness – the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

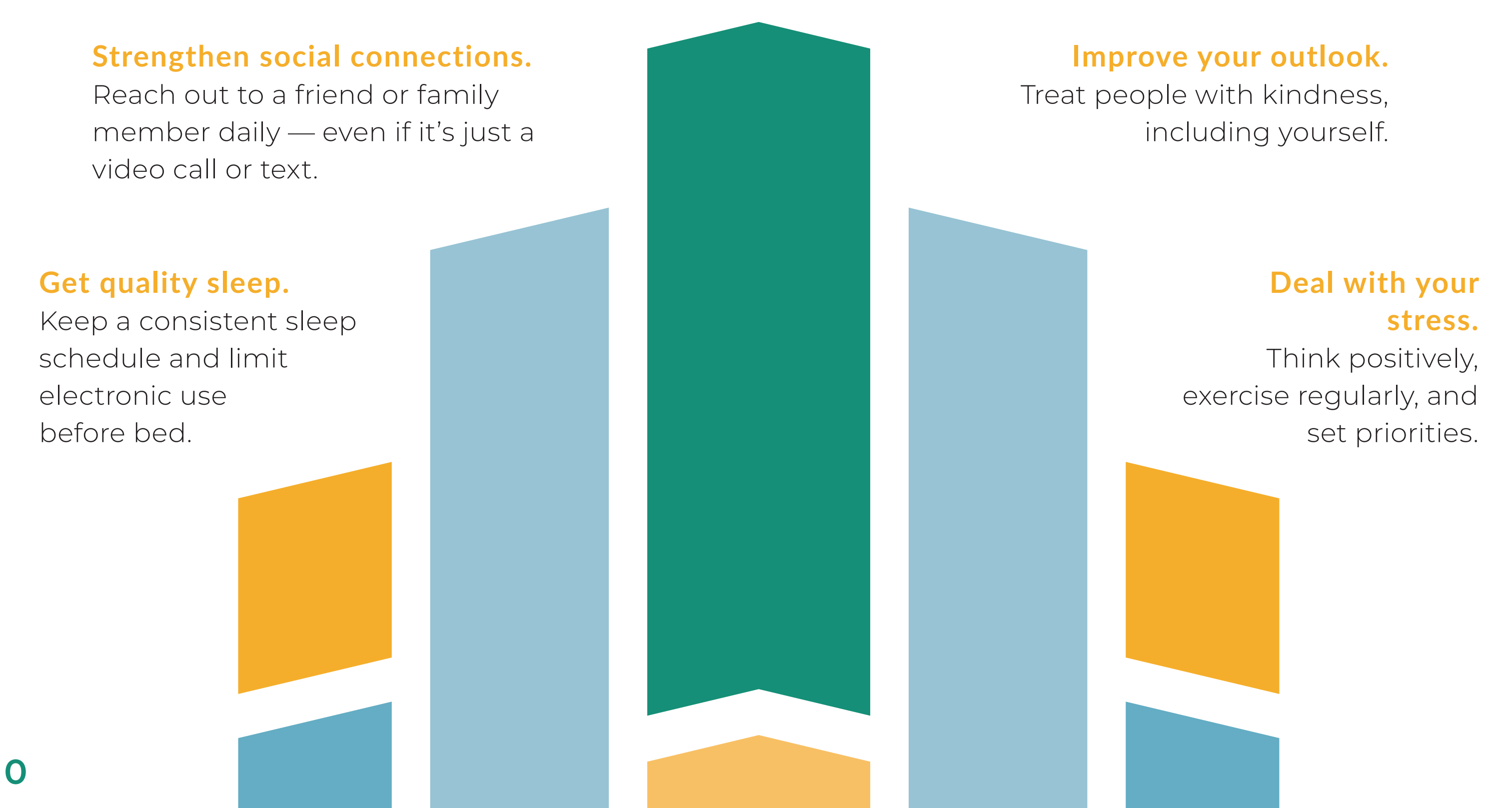
Practice mindfulness.
Practice deep breathing, enjoy a stroll, and stay present in each moment.

Strengthen social connections.
Reach out to a friend or family member daily — even if it's just a video call or text.

Improve your outlook.
Treat people with kindness, including yourself.

Get quality sleep.
Keep a consistent sleep schedule and limit electronic use before bed.

Deal with your stress.
Think positively, exercise regularly, and set priorities.



King's Daughters Team Member Assistance Program (TMAP)

The Team Members Assistance Program (TMAP) also known as the Employee Assistance Program (EAP) is a multifaceted program designed to provide a specialized counseling service for Team Members and their eligible dependents. The Team Members Assistance Program is designed to address a wide range of Team Members issues such as: coping with stress, mental health issues, family issues, financial issues, and legal issues. The Team Members Assistance Program offers a range of services to include:

- Mental health and substance misuse assessments
- Confidential, individual and family counseling
- Follow-up sessions
- Referrals to the most appropriate resource for the problem
- Training for supervisory personnel
- Critical incidence stress debriefing
- Orientation for Team Members
- Interventions for rapid problem resolution
- Consumer and Team Member education to prevent or reduce problems
- Technical assistance in designing and implementing mental health programs
- Record-keeping that meets state and federal laws regarding confidentiality

There is no charge or cost to the Team Member or the Team Member's family members when utilizing the King's Daughters Health System TMAP. If the Team Member or the Team Member's family member is referred to a community resource a cost may be involved from utilizing that resource. Often the service is covered by one's health insurance plan or based on a sliding fee scale according to one's ability to pay, or free.

Benefits of the Team Member Assistance Program

- It can assist with policy development, Team Member education, and supervisor training.
- It can assist supervisors and managers, when Team Member's personal problems affect job performance.
- It offers access to treatment for Team Members with problems that affect their job performance.
- It has been linked to decreases in accidents, workers compensation claims, absenteeism, health benefit utilization, and turnover rates.
- It can assist in development and compliance to the drug-free workplace laws.
- It has been linked with overall improvement in productivity and positive Team Member morale.
- It can enhance the work climate of an organization and promote the health and wellbeing of everyone involved.

Case Management

King's Daughters Health System Team Members Assistance program is conducted through the Occupational Medicine Department and managed by David Meade; Program Manager. Appointments can be arranged by calling 606-408-4982 or by email david.meade@kdmc.kdhs.us. Telehealth appointments are now available for Team Members whose service is originated from Kentucky or Ohio.

Confidentiality

Your privacy is an important concern. King's Daughters TMAP does not provide any information about anyone utilizing the program without a written consent from the individual. In all cases, information discussed is held in the strictest confidence. Participation in the TMAP is voluntary and based on the individual's decision to receive assistance.

ComPsych

Additional EAP services are available to King's Daughters team members through ComPsych.

Visit www.GuidanceResources.com or call 888-628-4824 for more information.

Other Mental Health Resources

No matter what the situation, whether you're a manager or entry-level team member, don't be afraid to ask for help. There are resources available 24/7.

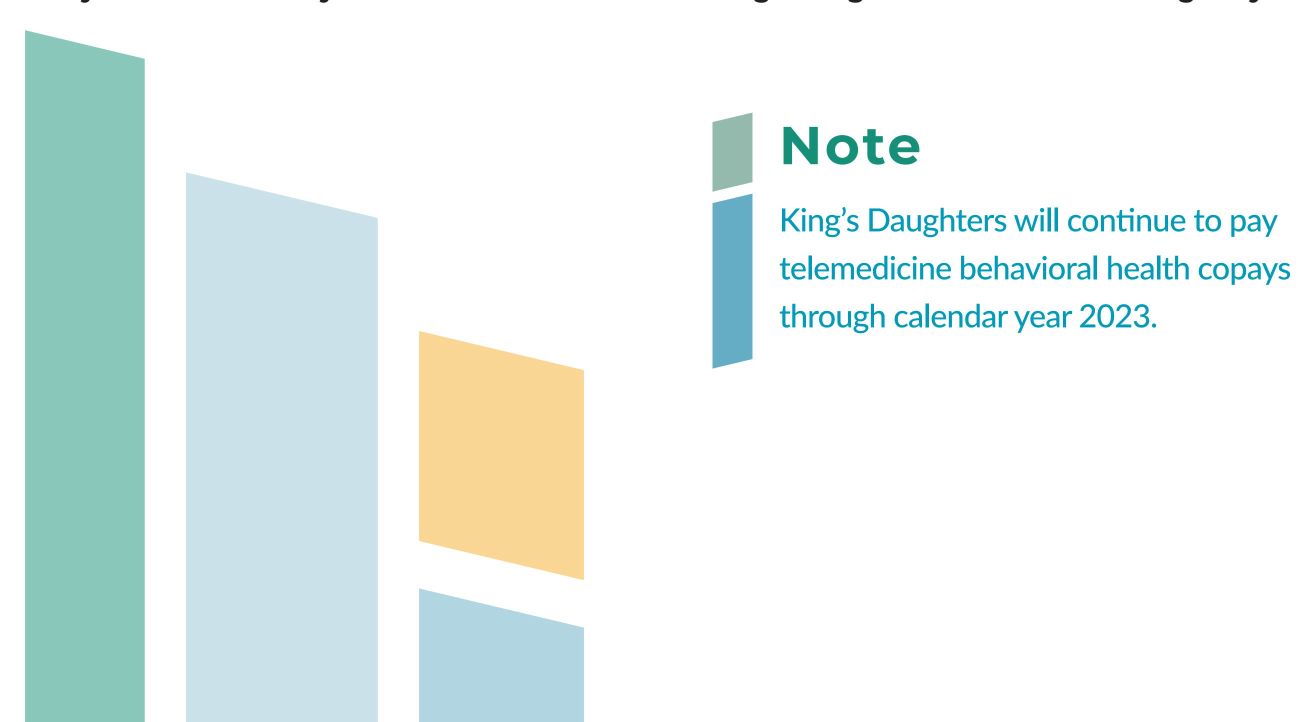
National Suicide Prevention Lifeline Call 988 The Lifeline is a free, confidential crisis hotline that connects callers to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals. 988 has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline (now known as the 988 Suicide & Crisis Lifeline), and is now active across the United States. The previous Lifeline phone number (1-800-273-8255) will remain available to people in emotional distress or suicidal crisis.

Crisis Text Line Text "HELLO" to 741741 Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

Veterans Crisis Line Call 988 and press 1 or text to 838255 The Veterans Crisis Lifeline serves our nation's Veterans, service members, National Guard and Reserve members, and those who support them. Veterans should continue to text the Veterans Crisis Lifeline short code: 838255. The service is available to all veterans, even if they are not registered with the VA or enrolled in VA healthcare.

There is hope. The 988 Suicide and Crisis Lifeline is a national network of more than 200 crisis centers that help thousands of people overcome crisis situations every day. These centers are supported by local and state sources as well as the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SSAMHSA). The 988 Lifeline provides 24/7, confidential support to people in suicidal crisis or mental health-related distress. By calling or texting 988, you will connect to mental health professionals within the Lifeline network. Numerous studies have shown that the callers feel less suicidal, less depressed, less overwhelmed and more hopeful after speaking with a Lifeline counselor.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.



Note

King's Daughters will continue to pay telemedicine behavioral health copays through calendar year 2023.

Medical Benefits

Medical benefits are administered by Aetna. Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2023 plan year unless you have a qualifying life event.

Our Plans are Self-Funded

Our medical, dental, and pharmacy plans are self-funded. What does that mean? Rather than paying premiums to an insurance carrier as with fully insured plans, King's Daughters pays for members' claims. Self-insured plans allow for more freedom in plan design.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your Bi-weekly contributions.

	BLUE PLAN	WHITE PLAN W/HSA
BI-WEEKLY TEAM MEMBER CONTRIBUTION		
TEAM MEMBER ONLY	$16.19	$112.76
TEAM MEMBER + SPOUSE	$51.48	$241.77
TEAM MEMBER + CHILD(REN)	$32.14	$189.45
TEAM MEMBER + FAMILY	$68.86	$370.40
BI-WEEKLY TOBACCO SURCHARGE (ADD TO BI-WEEKLY CONTRIBUTION)		
TOBACCO USER	$62.31	$62.31

Tobacco User Surcharge

Team members (and spouses if eligible to enroll) who have been tobacco free for the past six months will be required to attest during the online open enrollment process that they are not – and will not be – a tobacco user for 2023 plan year. **Any team member who fails to complete the online attestation confirming non-tobacco status will automatically receive the Tobacco User Surcharge.** If you make the decision to eliminate tobacco use, King's Daughters offers through Aetna a variety of Tobacco Cessation Journeys to support this effort.

How to Find a Provider

Visit www.aetna.com or call Customer Care at 866-987-0318 for a list of Aetna network providers.

Note

Preventive care offered by an in-network physician, like well-woman exams or annual physicals, is often covered at 100%.

Medical Plan Summary

This chart summarizes the 2023 medical coverage provided by King's Daughters. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	BLUE PLAN			WHITE PLAN W/HSA		
	KING'S DAUGHTERS FACILITY NETWORK	AETNA NETWORK	OUT-OF-NETWORK	KING'S DAUGHTERS FACILITY NETWORK	AETNA NETWORK	OUT-OF-NETWORK
DEDUCTIBLE TYPE	Embedded	Embedded	Embedded	Non-Embedded	Non-Embedded	Non-Embedded
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$1,300	$2,500	No Coverage	$1,700	$3,100	$5,300
FAMILY	$2,600	$5,000	No Coverage	$3,400	$6,200	$10,600
COINSURANCE (PLAN PAYS)	20%*	50%*	No Coverage	15%*	30%*	60%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)^						
INDIVIDUAL	$2,000	$7,150	No Coverage	$2,800	$5,600	$10,000
FAMILY	$4,000	$14,300	No Coverage	$5,600	$11,200	$20,000
COPAYS/COINSURANCE						
PREVENTIVE CARE	100%	100%	No Coverage	100%	100%	No Coverage
PRIMARY CARE	$30 copay	$60 copay	No Coverage	15%*	30%*	60%*
SPECIALIST SERVICES	$60 copay	$110 copay	No Coverage	15%*	30%*	60%*
INPATIENT	$150/day; $600 max per admit*	**No Coverage	No Coverage	15%*	30%*	60%*
OUTPATIENT	20%*	**No Coverage	No Coverage	15%*	30%*	60%*
URGENT CARE	$75 copay	$100 Copay	No Coverage	15%*	30%*	60%*
EMERGENCY ROOM	$250 copay			15%*		

*After deductible
**Service Line Carve-Outs – will only cover services provided at King's Daughters unless not available or approved; exceptions approved will process at the Aetna In-Network Tier
^Includes deductible and copays.

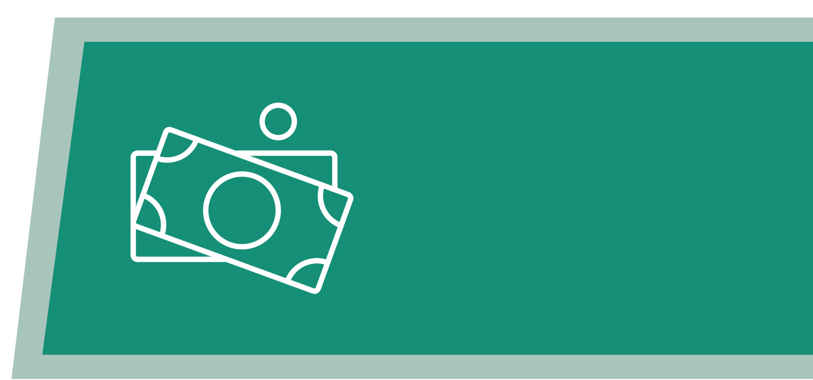
Please make sure to read the information below to better understand how your deductible and out-of-pocket maximums work:

Embedded Deductible: The Blue Plan has an embedded deductible which means each family member has an individual deductible in addition to the overall family deductible. If an individual in the family reaches his or her deductible before the family deductible is reached, their deductible is satisfied. The family deductible amount may be satisfied by a combination of two or more members covered under your medical plan. The same applies for the out-of-pocket maximum.

Non-Embedded Deductible: The White Plan, a Qualified High Deductible Plan, has an aggregate deductible. This type of deductible is when the health care costs for all your covered family members throughout the plan year are added together and applied toward the family deductible. Once your family deductible is met, coinsurance will kick in for each family member, and your plan will help pay their additional health care costs for the plan year. The same will apply for the out-of-pocket maximum.

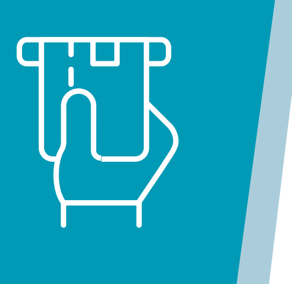
Out-of-Pocket Costs

These are the types of payments you're responsible for:



Copay

The fixed amount you pay for healthcare services at the time you receive them.



Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Coinsurance

Your percentage of the cost of a covered service. If your covered non-copay service is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

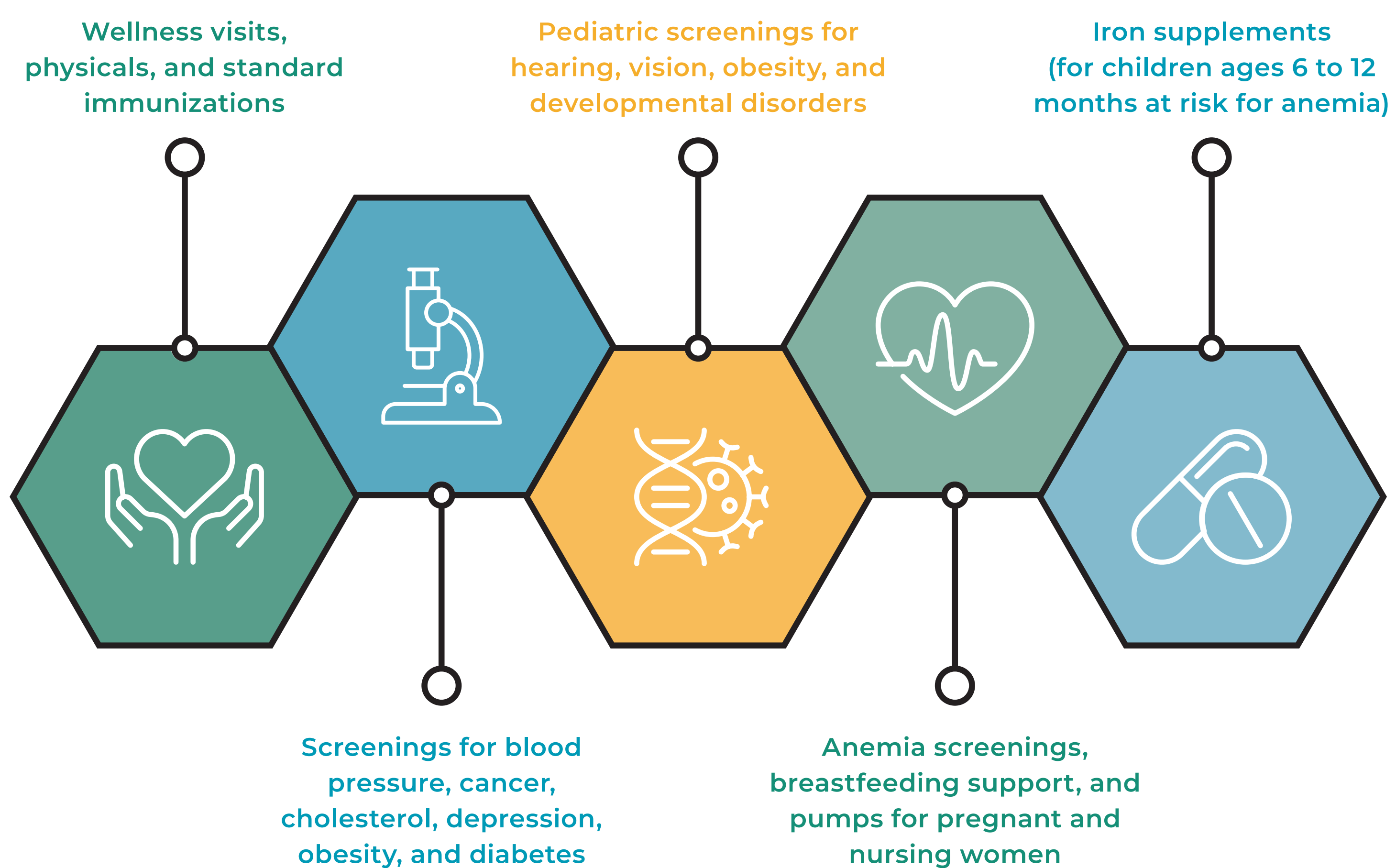
Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:



Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What about the COVID-19 vaccine? The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.

Diabetes Program

King's Daughters offers a Diabetes program to our eligible team members. The goal of this program is to increase education and decrease the risk of complications that may be caused by the condition.

To be eligible for the program you must be an active Full-Time or Part-Time team member and/or a dependent on the King's Daughters health plan diagnosed with Type 1, Type 2 or Gestational Diabetes and are receiving treatment for the condition. By participating in this program, you will be eligible for a 90-day voucher for free testing strips and lancets to be redeemed at the KDMC Family Pharmacy.

Basic Requirements:

- Complete initial assessment by nurse educator
- One visit with dietitian for initial assessment/education
- One group visit for education on prevention of acute/chronic complications

Expectation of Participants:

- Meeting with diabetes educator every 3 months for Diabetes Self-Management Education
- HBgA1C recheck every 3-6 months (or as determined by PCP)
- Bring blood sugar record or meter each visit with diabetes educator

Contact Center for Healthy Living at Ext 81547 to discuss the program and how it could help you decrease and/or control your blood glucose level.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Team members enrolled in medical coverage through Aetna have access to General Medical, Dermatology and Mental Health telemedicine services through Teledoc.

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

USE YOUR RESOURCES

24-HR NURSE LINE
800-556-1555

TELEDOC
855-Teledoc (835-2362)

MYCHART
844-324-2200

MEDICAL MEMBER SERVICES
866-987-0318

PHARMACY MEMBER SERVICES
888-792-3862

Teladoc is an affordable and convenient alternative to receive professional care, 24/7/365 for non-emergency issues, via phone, video, or mobile app, rather than going to urgent care or the ER.

The following conditions can be treated via Teladoc:

- Cold & flu symptoms
- Sinus infections
- Pink Eye
- Allergies
- Skin issues
- Support for stress, anxiety, depression, and other mental health concerns
- And many more!

Teladoc is offered to all team members, regardless if you're enrolled in a King's Daughters medical plan, or not. The price for services if you are enrolled in a King's Daughters medical plan, or not, is reflected below.

	NOT ENROLLED IN A KDMC MEDICAL PLAN	BLUE PLAN	WHITE PLAN
		KDMC FACILITY NETWORK	
SERVICE			
EVERYDAY CARE (General Medical / Urgent Care)	$75	$30^	$49 or less*
MENTAL HEALTH CARE			
Therapist Visit (Non-MD)	$99	$60^	$85 or less*
Initial Psychiatry Visit (MD)	$229	$60^	$190 or less*
Ongoing Psychiatry Visits (MD)	$119	$60^	$95 or less*
DERMATOLOGY	$95	$60^	$75 or less*

All prices shown reflect a per visit cost.

Any discrepancies between the information provided and the plan document, the plan document will supersede.
Any discrepancies between the information provided and Teladoc's policies, Teladoc's policies will supersede.

^ Deductible does not apply
*Cost for service, until deductible is met, then subject to co-insurance.

MyChart

MyChart from King's Daughters is a great way to stay connected to your medical care. This tool is available 24/7 over a secure internet connection. And, best of all, it is free.

Signing up is simple!

Call our Care 24/7 service toll free at 844-324-2200 or 606-408-8999. Our team will walk you through the steps to get you MyChart account set up – easy-peasy.

If you prefer, visit our website, KingsDaughtersHealth.com and click on the MyChart icon at the top right of the page to sign up.

Or, next time you visit King's Daughters, ask your registration clerk to sign you up!

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is self-insured and coordinated through Aetna. That means you will only have one ID card for both medical care and prescriptions. You will continue to have the option of filling your prescriptions at the King's Daughters Family Pharmacy, which offers you a lower copay and the convenience of a payroll deduction. You may also access one of Aetna's contracted pharmacies or mail order service. Your cost is determined by the pharmacy you access and the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, or Non-Preferred.

You may find information about your benefits coverage and search for network pharmacies by logging on to www.aetna.com or by calling the Customer Care number on your ID Card.

	BLUE PLAN		WHITE PLAN W/HSA	
	KDMC PHARMACY	AETNA PHARMACY	KDMC PHARMACY	AETNA PHARMACY
RETAIL RX (30-DAY SUPPLY)				
GENERIC	$7 copay	$20 copay	15%*	30%*
PREFERRED	$25 copay	$50 copay	15%*	30%*
NON-PREFERRED	$50 copay	$80 copay	15%*	30%*
MAIL ORDER RX (90-DAY SUPPLY)				
GENERIC	$15 copay	$25 copay	15%*	30%*
PREFERRED	$60 copay	$95 copay	15%*	30%*
NON-PREFERRED	$120 copay	$155 copay	15%*	30%*

*After deductible

Is My Drug Covered?

Visit www.aetna.com or call the Customer Care number on your ID Card.

Note: Apps like GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. Make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. So if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Note

Mandatory 90-day fills for maintenance prescriptions can only be filled at a KDMC Family Pharmacy or Aetna Rx Mail Order (two thirty-day fills are allowed).

Q&A: Generic Drugs

Visit www.aetna.com or call the Customer Care number on your ID Card to find out if your drug is covered on the formulary.

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the innovator drug (inactive ingredients may vary).
- Be identical in strength, dosage form, and route of administration.
- Have the same use indications.
- Be bioequivalent.
- Meet the same batch requirements for identity, strength, purity, and quality.
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products.

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in an HDHP, like the White Plan to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

WEX will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Tax-free Interest

Team Member Contributions (pre-tax)

Voluntary Contributions

Tax-free Payments
(for qualified medical expenses)

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in the White Plan, an HSA-eligible Qualified High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP.
- Your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in King's Daughters' HSA, you must elect the White Plan with King's Daughters. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. King's Daughters will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with WEX. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

Note

Not sure how much to contribute? Think about how much you may need in order to cover any anticipated or emergency medical services this year. Consider contributing the amount of your plan's in-network deductible so you know you're covered.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2023, contributions are limited to the following:

HSA FUNDING LIMITS	
TEAM MEMBER	$3,850
FAMILY	$7,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits ($3,850 for individual coverage and $7,750 for family coverage for 2023) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The King's Daughters HSA is established with WEX. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources at 606-408-0022 or visit www.wexinc.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $2,850 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Limited Use Flexible Spending Account

A Limited Use Flexible Spending Account (LUFSA) works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. The contribution limit is $2,850.

Note

You can use your Healthcare FSA funds to pay for deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, and more.

Note

Don't forget, the Child Development Center (CDC) located at 2419 Lexington Avenue, Ashland, KY, is an eligible day care provider. You can use your DFSA towards your child's care at the CDC.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the team member for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact WEX with reimbursement questions. If you need to submit a receipt, WEX will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. We have provided WEX with a list of the acceptable copay amounts associated with the KDMC plans but you will need to substantiate claims as requested by WEX. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2023 plan year.
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated team members have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated team members (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for eligible healthcare costs. Which one is best for you?

	FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNTS
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA. If you are enrolled in the HSA plan you can enroll in the Limited Purpose FSA. See the Other Types section for more information.	1. You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year. 3. You are able to enroll in a Limited Purpose FSA. Please see the Other Types section for more information on the Limited Purpose FSA.
TAXATION	Contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free when used for qualified expenses.
CONTRIBUTIONS	You can contribute according to IRS limits. The contribution limit for the Healthcare FSA for 2023 is $2,850. You have 90 days after the plan year close to use your funds for claims from the 2023 plan year. Any funds that you do not use will be forfeited after the 90 days.	You can contribute according to IRS limits. The contribution limit for 2023 is $3,850 for individuals and $7,750 for families. This includes the employer contribution. If you are 55 or older, you may make an annual "catch-up" contribution of $1,000.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal, or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or you may use another account to pay for services and save the money in your HSA for future expenses or retirement.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
OTHER TYPES	• Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care. • Limited Use FSA (LUFSA) - Only covers eligible dental and vision expenses. LUFSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Healthcare FSA and an HSA.	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

	FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNTS
OWNERSHIP	Q: Who owns the account? A: Your *employer* owns the account.	Q: Who owns the account? A: *You* own the account.
TYPES OF ACCOUNTS	Q: What are the 3 types of FSA? A: The 3 types of FSAs are: HealthCare-FSA Limited Purpose *(*Note: You may use this type of FSA with a HSA)* Dependent Care	Q: Are there different types of HSAs, like there are with FSAs? A: No. There is only one type of HSA.
ELIGIBILITY, ENROLLMENT, AND ELECTION	Q: How do I become eligible for a FSA? A: You must be enrolled in an eligible medical plan. Q: When can I enroll in a FSA? A: You may enroll in a FSA only during Open Enrollment or your New Hire enrollment window, unless you have a Qualifying Life Event. Q: When can I make my election? A: You may only make your election during Open Enrollment or your New Hire enrollment window, unless you have a Qualifying Life Event. Q: Can I change my election mid-year? A: Only if you have Qualifying Life Event.	Q: How do I become eligible for a HSA? A: You must be enrolled in the White Plan, a Qualified High Deductible Health Plan medical plan. You cannot be covered under your spouse's/ or another person's plan and not enrolled in Medicare/Tricare. Q: When can I enroll in a HSA? A: You may enroll in a HSA any time during the year. Q: When can I make my election? A: You may make your election during Open Enrollment Q: Can I change my election mid-year? A: Yes. You may change your election during the year.
TAXATION	Q: Are my contributions to the FSA tax-free? A: Yes!	Q: Are my contributions to the HSA tax-free? A: Yes! In fact, they're ""triple tax-free."" This means, the contributions are tax-free, the account grows in value tax-free, and funds spent are tax-free (when used on qualified expenses.)
CONTRIBUTIONS	Q: What are the FSA contribution limits? A: The 2023 FSA contribution limits are: HealthCare-FSA = $2,850 Limited Purpose = $2,850 Dependent Care = $5,000	Q: What are the HSA contribution limits? A: The 2023 HSA contribution limits are: Single = $3,850 Family = $7,750 If you are 55+, you may contribute an additional $1,000
PAYMENT	Q: How do I pay for my expenses? A: You have one of two options: 1. Via your debit card, sent to you by WEX. 2. You pay for your expense, request a claim form and then submit for reimbursement to WEX.	Q: How do I pay for my expenses? A: You have one of two options: 1. Via your debit card, sent to you by WEX. 2. You pay for your expense and then submit reimbursement to WEX.
ROLL OVER	Q: Does my money roll over to the next plan year? A: No. Any unused funds are forfeited.	Q: Does my money roll over to the next plan year? A: Yes! This is your account and you own all the money in the account.
QUALIFIED EXPENSES	Q: What can I use the money for? A: You may use the funds for qualified expenses, such as: Healthcare-FSA = Physician services, hospital services, dental care, and vision Limited Purpose = Dental and vision care Dependent Care = Qualified child/elder care For a complete list of eligible expenses, visit: www.irs.gov	Q: What can I use the money for? A: You may use the funds for qualified expenses, such as: Physician services, hospital services, dental care, vision, and COBRA premiums. For a complete list of eligible expenses, visit: www.irs.gov

Supplemental Health Benefits

King's Daughters offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any financial impact. Accident coverage through MetLife provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits are payable to you to use as you wish.

BI-WEEKLY CONTRIBUTIONS		
	LOW	HIGH
TEAM MEMBER ONLY	$2.98	$5.22
TEAM MEMBER + SPOUSE	$4.40	$7.83
TEAM MEMBER + CHILD(REN)	$5.60	$9.96
TEAM MEMBER + FAMILY	$7.15	$12.83

ACCIDENTAL COVERAGE BENEFITS	LOW PLAN BENEFITS	HIGH PLAN BENEFITS
FRACTURE BENEFIT	$100 – $8,000	$250 – $12,000
DISLOCATION BENEFIT	$100 – $8,000	$250 – $12,000
SECOND OR THIRD DEGREE BURN BENEFIT	$75 – $10,000 depending on the degree of the burn and the percentage of burnt skin	$150 – $17,500 depending on the degree of the burn and the percentage of burnt skin
CONCUSSION BENEFIT	$250	$750
COMA BENEFIT	$7,500	$15,000
LACERATION BENEFIT	$50 – $400 depending on the length of the cut and type of repair	$100 – $800 depending on the length of the cut and type of repair
AMBULANCE BENEFIT	Ground: $300 Air: $1,000	Ground: $500 Air: $1,500
EMERGENCY CARE BENEFIT	$75 – $150 depending on location of care	$125 – $250 depending on location of care
NON-EMERGENCY INITIAL CARE BENEFIT	$75	$125
PHYSICIAN FOLLOW-UP VISIT BENEFIT	$75	$125
THERAPY SERVICES BENEFIT (including physical therapy)	$35	$65
MEDICAL TESTING BENEFIT	$150	$250
MEDICAL APPLIANCE BENEFIT	$75 – $750 depending on the appliance	$200 – $1,250 depending on the appliance
PROSTHETIC DEVICE BENEFIT	One device: $750 More than one device: $1,500	One device: $1,250 More than one device: $2,500
BLOOD/PLASMA/PLATELETS BENEFIT	$400	$600
SURGICAL REPAIR BENEFIT	$150-$1,500 depending on the type of surgery	$250-$2,500 depending on the type of surgery
OTHER OUTPATIENT SURGERY BENEFIT	$300	$500
PARALYSIS	$10,000 - $20,000 depending on the number of limbs	$30,000 - $60,000 depending on the number of limbs
HEALTH SCREENING BENEFIT	$50	$50

Critical Illness Coverage

Critical Illness coverage through MetLife pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Team Member: $15,000 or $30,000
  - Spouse: 100% of team member's initial benefit
  - Child(ren): 100% of team member's initial benefit
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion; however, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.
- Wellness Benefit: A $50 wellness benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy, or stress test.

Covered Benefits

(paid at 100% of your elected benefit amount unless otherwise noted):

- Heart Attack
- Stroke
- Coronary Artery Bypass (50%)
- Invasive Cancer
- Carcinoma in Situ (25%)
- Skin Cancer (5%)
- Benign Brain Tumor
- End Stage Renal Failure
- Major Organ Failure
- Alzheimer's Disease
- Coma
- Complete Blindness
- Complete Loss of Hearing
- Infectious Disease (25%)
- Amyotrophic Lateral Sclerosis (ALS)
- Multiple Sclerosis
- Occupational HIV
- Parkinson's Disease
- Permanent Paralysis
- Cerebral Palsy
- Cleft Palate
- Cystic Fibrosis
- Diabetes - Type 1
- Down Syndrome
- Sickle Cell Anemia
- Spina Bifida
- Severe Burn

PLUS PLAN $30,000 COVERAGE (BI-WEEKLY CONTRIBUTION)

TEAM MEMBER'S AGE	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE	TEAM MEMBER + CHILD(REN)	TEAM MEMBER + FAMILY
<25	$4.43	$8.86	$10.66	$15.09
25 - 29	$4.71	$9.83	$10.94	$16.06
30 - 34	$6.37	$13.43	$12.60	$19.66
35 - 39	$8.86	$19.25	$15.09	$25.48
40 - 44	$13.02	$28.80	$19.25	$35.03
45 - 49	$19.25	$43.06	$25.48	$49.29
50 - 54	$27.14	$62.31	$33.37	$68.54
55 - 59	$37.11	$88.06	$43.34	$94.29
60 - 64	$53.03	$128.49	$59.26	$134.72
65 - 69	$79.48	$193.02	$85.71	$199.25
70 - 74	$122.95	$289.80	$129.18	$296.03
75 - 79	$190.52	$436.43	$196.75	$442.66
80 - 84	$299.35	$649.11	$305.58	$655.48
85+	$398.77	$846.97	$405.14	$853.20

BASE PLAN $15,000 COVERAGE (BI-WEEKLY CONTRIBUTION)

TEAM MEMBER'S AGE	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE	TEAM MEMBER + CHILD(REN)	TEAM MEMBER + FAMILY
<25	$2.22	$4.43	$5.33	$7.55
25 - 29	$2.35	$4.92	$5.47	$8.03
30 - 34	$3.18	$6.72	$6.30	$9.83
35 - 39	$4.43	$9.62	$7.55	$12.74
40 - 44	$6.51	$14.40	$9.62	$17.52
45 - 49	$9.62	$21.53	$12.74	$24.65
50 - 54	$13.57	$31.15	$16.68	$34.27
55 - 59	$18.55	$44.03	$21.67	$47.15
60 - 64	$26.52	$64.25	$29.63	$67.36
65 - 69	$39.74	$96.51	$42.85	$99.62
70 - 74	$61.48	$144.90	$64.59	$148.02
75 - 79	$95.26	$218.22	$98.38	$221.33
80 - 84	$149.68	$324.55	$152.79	$327.74
85+	$199.38	$423.48	$202.57	$426.60

This list is a summary. Refer to plan documents for a comprehensive list of covered benefits and eligibility.

Hospital Indemnity Coverage

Hospital Indemnity coverage through MetLife pays you cash benefits directly if you are admitted to the Hospital, an Intensive Care Unit (ICU), a Mental Health Facility or a Substance Use Center for a covered stay. You can use the benefits to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion. Benefits are payable for hospitalizations that occur on or after the effective date of your policy.
- Age Reduction applies. Coverage reduces by 25% at age 65.

BENEFIT AMOUNT	
INITIAL CONFINEMENT BENEFIT FOR HOSPITAL OR CRITICAL CARE UNIT	$1,000
INITIAL CONFINEMENT FOR CRITICAL CARE UNIT	$2,000
DAILY BENEFIT FOR HOSPITAL CARE	$200
DAILY BENEFIT FOR CRITICAL CARE	$400

BI-WEEKLY CONTRIBUTIONS	
TEAM MEMBER ONLY	$8.94
TEAM MEMBER + SPOUSE	$15.73
TEAM MEMBER + CHILD(REN)	$13.53
TEAM MEMBER + FAMILY	$20.32

This list is a summary. Refer to plan documents for a comprehensive list of covered benefits and eligibility.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. King's Daughters offers an affordable plan option for routine care and beyond. Your dental coverage is self-insured by King's Daughters and claims are processed by Delta Dental.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Delta Dental of KY at www.deltadentalky.com. **See next page on how to save money by utilizing a Delta Dental PPO Network Dentist.**

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your Bi-weekly premium.

Dental Plan Summary

The chart summarizes the dental coverage provided by King's Daughters for 2023.

	DELTA DENTAL OF KY	
BI-WEEKLY CONTRIBUTIONS		
TEAM MEMBER ONLY	$1.42	
TEAM MEMBER + SPOUSE	$2.83	
TEAM MEMBER + CHILD(REN)	$3.24	
TEAM MEMBER + FAMILY	$4.65	
	IN-NETWORK (PPO & PREMIER)	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
CALENDAR YEAR MAXIMUM		
PER PERSON	$1,000	$1,000
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100%	100%
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	80%*	80%*
MAJOR SERVICES** Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50%*	50%*
ORTHODONTICS** Dependent Child(ren) Only	50%	
ORTHODONTIC LIFETIME MAXIMUM	$1,000 (For dependents under 19)	

*After deductible
**There is a 12-month waiting period for Major Services and Orthodontics

Note

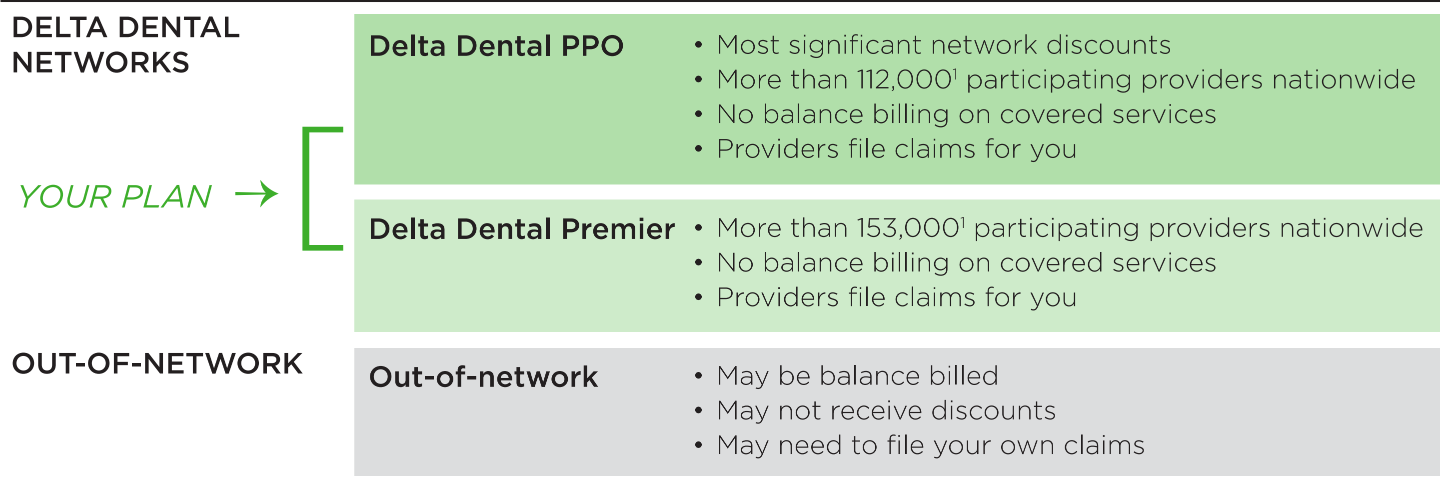
Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Delta Dental of Kentucky

PPO Plus Premier™ Plan Network Savings

Save Money and Stay in Network

With a PPO Plus Premier dental plan, visiting a Delta Dental PPO™ dentist provides the most significant discounts resulting in lowest out-of-pocket costs. In-network PPO dentists have agreed to accept lower fees as full payment for covered services. However, if a dentist doesn't participate in Delta Dental PPO, you can still save money with a Delta Dental Premier® participating dentist. Like our PPO dentists, Delta Dental Premier dentists agree to accept Delta Dental's fee determination as full payment for covered services.



[1]National network statistics: Delta Dental Plans Association March 2021

Examples of how it works:

As shown below, staying in network can help save you on out-of-pocket costs.*

		DELTA DENTAL PPO NETWORK DENTIST	DELTA DENTAL PREMIER NETWORK DENTIST	OUT OF NETWORK DENTIST
COMPOSITE FILLING (D2392) *May be subject to deductible*	Submitted fee:	$176.00	$176.00	$176.00
	Maximum allowed fee:	$124.00	$143.00	$87.00
	Coverage level:	80%	80%	80%
	Amount Delta Dental pays:	$99.20	$114.40	$69.60
	AMOUNT YOU PAY:	**$24.80**	**$28.60**	**$106.40**
CROWN (D2740) *May be subject to deductible*	Submitted fee:	$952.00	$952.00	$952.00
	Maximum allowed fee:	$660.00	$813.00	$462.00
	Coverage level:	50%	50%	50%
	Amount Delta Dental pays:	$330.00	$406.50	$231.00
	AMOUNT YOU PAY:	**$330.00**	**$406.50**	**$721.00**

**Payment examples shown above are illustrative only. Fees and reimbursements can vary by location and provider. Benefit coverages, levels and deductibles may vary by client. They do, however, represent how payment is determined.*

Members can get estimated cost ranges for common dental services using Delta Dental's mobile app. The app also provides the ability to search for a Delta Dental PPO or Delta Dental Premier dentist in their area. The Delta Dental mobile app is available for mobile devices using iOS (Apple) or Android.

Delta Dental of Kentucky | ky.deltadental.com | 800-955-2030

Delta Dental of Kentucky has provided more than $20 million to Non-profits across Kentucky since 2003.

®Registered Mark of Delta Dental Plans Association

Rev. 05/2021

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through Avesis.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your Bi-weekly premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by Avesis for 2023.

	BASE OPTION	BUY-UP OPTION*
BI-WEEKLY CONTRIBUTIONS		
TEAM MEMBER ONLY	$2.02	$3.25
TEAM MEMBER + SPOUSE	$3.70	$6.19
TEAM MEMBER + CHILD(REN)	$4.18	$6.91
TEAM MEMBER + FAMILY	$5.54	$9.11

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

You can contact Avesis directly at 1-800-828-9341 or by visiting their website www.avesis.com if you have questions about coverage, network providers or your ID card.

	BASE OPTION		BUY-UP OPTION*	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
BENEFITS				
VISION CARE SERVICES (ONCE EVERY 12 MONTHS)				
VISION EXAM	$25 copay, then covered in full	Up to $35	$25 copay, then covered in full	Up to $35
CONTACT LENS FIT AND FOLLOW-UP				
STANDARD CONTACT LENS FITTING	Up to $50 member out-of-pocket maximum	N/A	Up to $50 member out-of-pocket maximum	N/A
MATERIALS**				
	$25 copay (materials copay applies to frame or spectacle lenses, if applicable)		$25 copay (materials copay applies to frame or spectacle lenses, if applicable)	
FRAMES (ONCE EVERY 24 MONTHS)				
FRAME ALLOWANCE (Up to 20% discount above frame allowance)	$150	Up to $50	$150	Up to $50
STANDARD SPECTACLE LENSES (ONCE EVERY 12 MONTHS*)**				
SINGLE VISION	$25 copay, then covered in full	Up to $25	$25 copay, then covered in full	Up to $25
BIFOCAL	$25 copay, then covered in full	Up to $40	$25 copay, then covered in full	Up to $40
TRIFOCAL	$25 copay, then covered in full	Up to $50	$25 copay, then covered in full	Up to $50
PREFERRED PRICING				
POLYCARBONATE (Single Vision/Multi-Focal)	$40/$44 (Covered in full up to age 19)	N/A (Up to $10 for ages up to 19)	Covered in full	Up to $10
STANDARD SCRATCH-RESISTANT COATING	$17	N/A	Covered in full	Up to $5
STANDARD ANTI-REFLECTIVE COATING	$45	N/A	Covered in full	Up to $24
LEVEL 1 PROGRESSIVES	$75	Up to $40	Covered in full	Up to $40
TRANSITIONS® (SINGLE VISION/MULTI-FOCAL)	$70/$80	N/A	$70/$80	N/A
POLARIZED	$75	N/A	$75	N/A
OTHER LENS OPTIONS	Up to 20% discount	N/A	Up to 20% discount	N/A
CONTACT LENSES (IN LIEU OF FRAME AND SPECTACLE LENSES) (ONCE EVERY 12 MONTHS*)**				
ELECTIVE (10% discount on amount exceeding allowance)	$40/$44 (Covered in full up to age 19)	N/A (Up to $10 for ages up to 19)	Covered in full	Up to $10
REFRACTIVE LASER SURGERY (ONE TIME / LIFETIME)				
	$150 allowance Provider discount up to 25%	$150 allowance	$150 allowance Provider discount up to 25%	$150 allowance

Medically Necessary Contact Lenses - Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following specific conditions: Anisometropia, High Ametropia or Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.

*High option provides additional preferred pricing for specific benefits at no or low cost when compared to the low option.
**Discounts are not insured benefits.
***You have option of getting spectacle lenses or contact lenses, once every 12 months.

If there are any discrepancies between the information in this benefit guide and the Plan Documents, the Plan Documents will supersede.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

King's Daughters provides team members with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Lincoln Financial, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the Lincoln Financial insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

Optional Dependent Life Insurance

In 2023 we will be offering increased Life benefits for your spouse and/or your dependent children. When you work through your enrollment you will want to review the new options available, which are laid out in the chart below.

OPTIONAL SPOUSE LIFE	
COVERAGE AMOUNT OPTIONS	Option 1 - $5,000 Option 2 - $10,000 Option 3 - $25,000 Option 4 - $50,000
COST OF COVERAGE PER BI-WEEKLY PAYCHECK	See age banded rates, cost is per $1,000 of coverage
WHO PAYS	Team Member
EVIDENCE OF INSURABILITY	Not required for 2023 elections
OPTIONAL CHILD(REN) LIFE	
COVERAGE AMOUNT OPTIONS	Option 1 - $5,000 Option 2 - $10,000 Option 3 - $20,000
COST OF COVERAGE PER BI-WEEKLY PAYCHECK	Option 1 - $0.923 Option 2 - $1.846 Option 3 - $3.692
WHO PAYS	Team Member
EVIDENCE OF INSURABILITY	Not required for 2023 elections

STEP RATES (PER $1,000 OF BENEFIT)	SPOUSE
0-24	$0.029
25-29	$0.029
30-34	$0.038
35-39	$0.043
40-44	$0.051
45-49	$0.077
50-54	$0.117
55-59	$0.220
60-64	$0.337
65-69	$0.649
70-90+	$1.053

If you would like to keep your current Optional Dependent Life elections, we are able to grandfather those amounts. However, if you were to drop the coverage to elect one of the new amounts after the 2023 Open Enrollment you will have to complete Evidence of Insurability (EOI).

Income Protection

You and your loved ones depend on your regular income. That's why King's Daughters offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating illness or injury. A portion of your income is protected until you can return to work or you reach retirement age.

Voluntary Short Term Disability (STD) Insurance

Short Term Disability is available to full-time team members. This insurance replaces up to 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are provided by King's Daughters at no cost after one year in a full-time position. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

Note

Around 30% of Americans ages 35-65 will suffer a disability lasting at least 90 days during their careers. (Source: Million Dollar Round Table)

Retirement Planning

It's never too early — or too late — to start planning for your retirement. Team members making contributions to a retirement account is the first step toward achieving financial security later in life. The King's Daughters Defined Contribution retirement plan provides you with the tools and flexibility you need to retire comfortably and securely.

All eligible team members can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this Plan are provided by Empower Retirement.

Eligibility

You may start making pre-tax contributions into the plan immediately.

Contributing to the Plan

The deferred contribution limit, which is set annually by the IRS, is $22,500 for 2023. Ages 50 and older may make an additional $7,500 contribution.

Catch-up Contributions

If you are or will be age 50 or older during the 2023 calendar year and you already contribute the maximum allowed to your 403(b) and/or Roth account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $7,500 for 2023 for a combined total contribution allowance of $30,000.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer or roll over that account into the plan any time. To initiate a rollover into your plan, contact Empower Retirement at 866-467-7756 for details.

Investing in the Plan

You decide how to invest the assets in your account. The King's Daughters Defined Contribution retirement plan offers a selection of investment options for you to choose. You may change your investment choices any time. For more details, contact Empower Retirement at 866-467-7756 or visit the website at empowermyretirement.com.

Note

Additional information and educational videos are available at www.kdhsbenefits.com.

Automatic Retirement Enrollment Feature

King's Daughters is committed to helping you achieve more financial freedom in retirement and made the move to automatically enroll new full-time and part-time non-bargaining team members in the retirement plan.

After one month of employment, you will begin contributing 3% of your salary on a before-tax basis through the convenience of payroll deduction. That 3% of your salary will be invested in an American Funds Target Date Fund according to the number of years remaining until you reach normal retirement age - 65 years.

If you do not want to participate, you can do so by signing the declination form on the following page and then return it to Human Resources. You may stop or change your percentage at any time in the future. Take advantage of services available to you on Empower Retirement's participant website at empowermyretirement.com. To enroll yourself follow these steps:

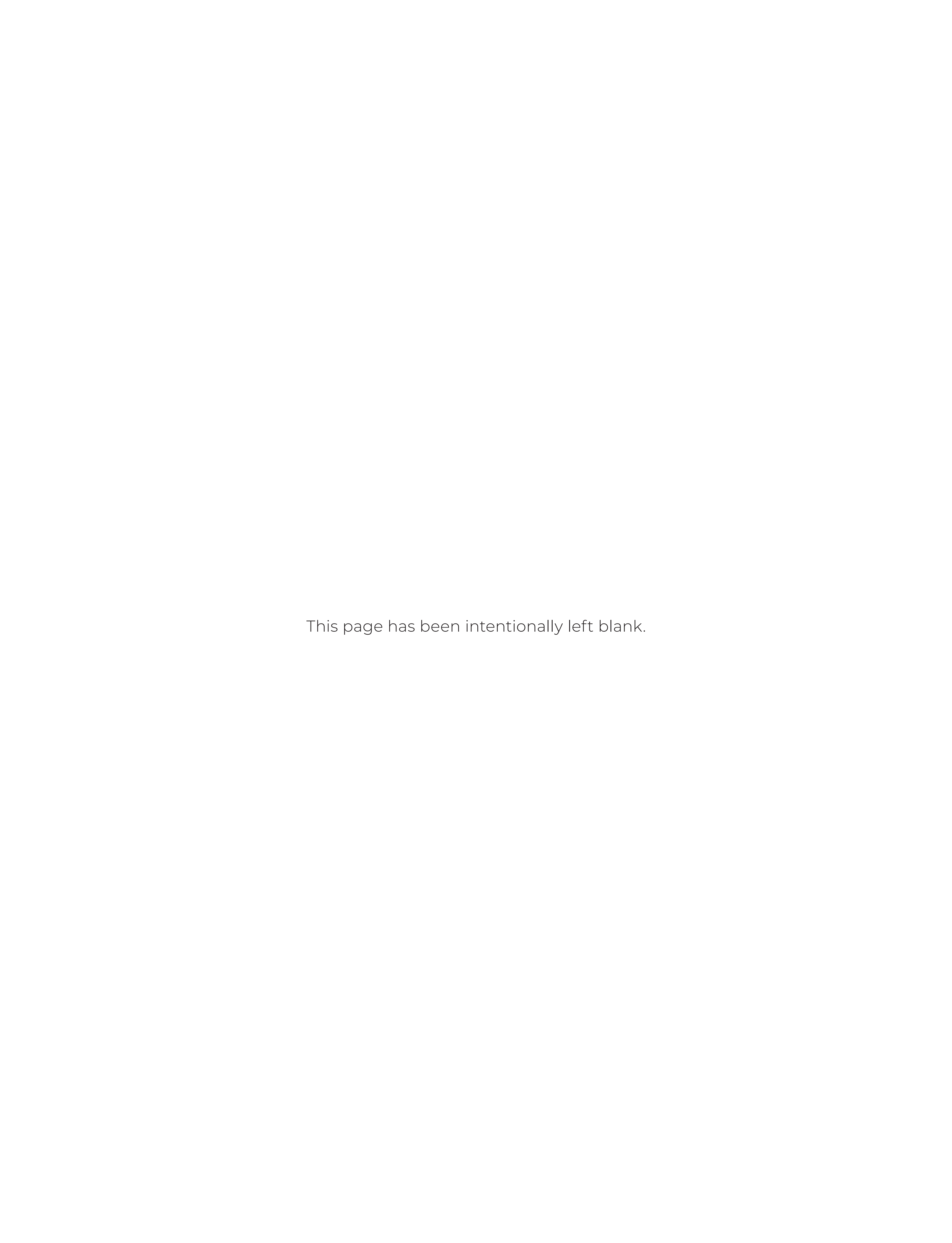
- Visit empowermyretirement.com
- Select the 'I do not have a Pin' tab
- Enter your personal information
- Create a username and password
- Select 'Sign in' going forward

We also have on-site financial representatives available:

Gino Cox & Carla Adkins
606-326-0203

Note

The beneficiary named on your life insurance is not applicable for your retirement accounts. Please remember to elect a beneficiary for your retirement account(s). You are able to enter the beneficiary information through your Empower website account or contact Human Resources if you have questions.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King's Daughters
Defined Contribution Retirement Plan
Election Not To Participate

Section 1 Participant Information

Name ____

Social Security Number ____

Date of Hire ____

Team Member ID Number ____

Section 2 Election Not to Participate

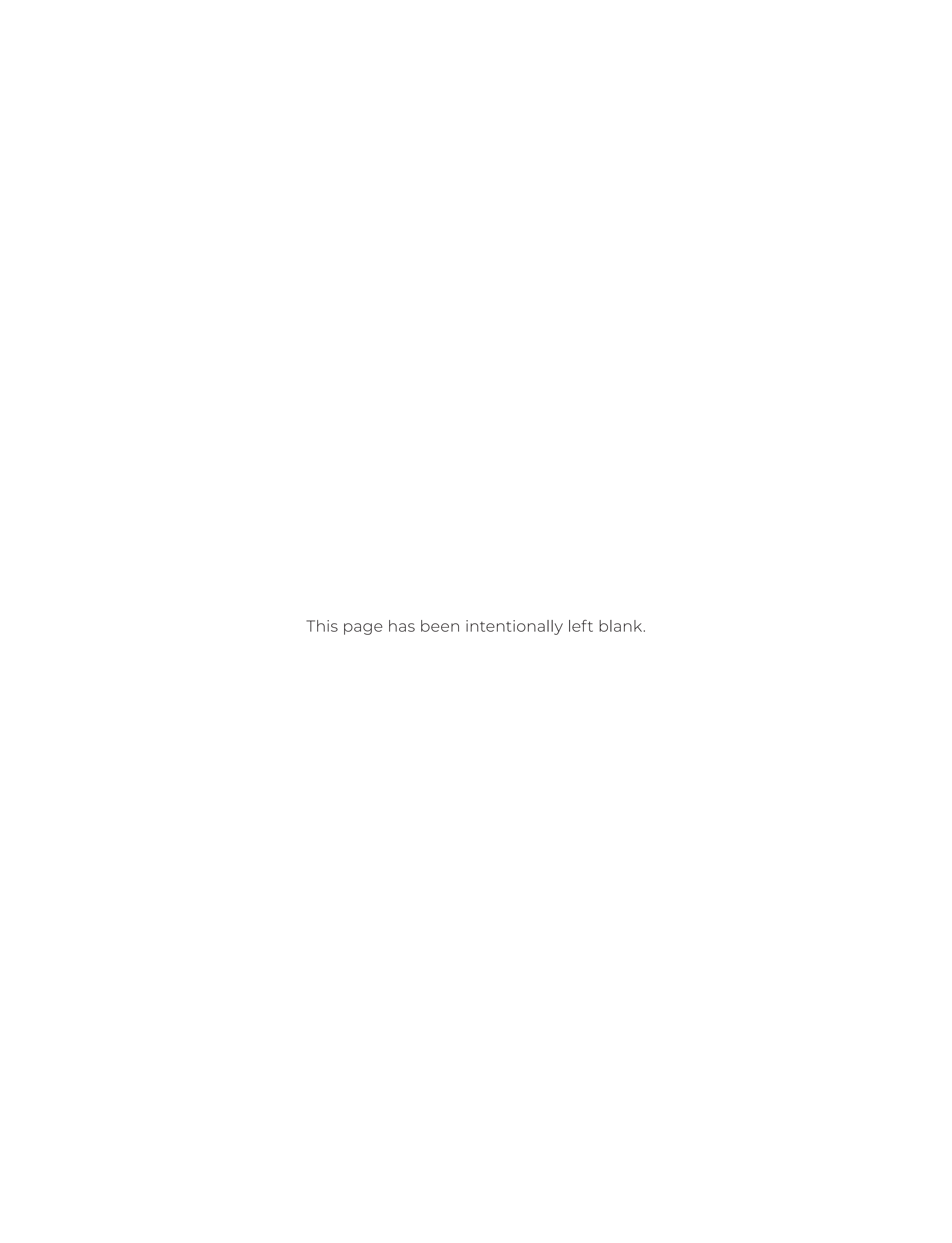
I understand that the King's Daughters Medical Center Matching Contribution Plan (the "Plan") has an automatic enrollment feature and that I am eligible to participate in the Plan. I have read and understand the notice provided to me, and I do not wish to participate in the Plan at this time. By signing below, I understand and agree that no percentage of my eligible pay will be deducted and contributed to the Plan on my behalf. I further understand that, if I remain employed in an eligible classification, I can elect to contribute in the future by contacting our Retirement Plan Sponsor or Human Resources and enrolling.

______________________________ ______________________

Team Member Signature Date

______________________________ ______________________

Human Resources Signature Date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Additional Benefits

King's Daughters wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Child Development Center at King's Daughters

Enroll Today

- For children six weeks to age 5
- Certified lead teachers and assistants
- 8 classrooms, plus indoor and outdoor play areas
- Safe and secure. Front desk monitors access to entrances leading to classrooms
- Seasonal activities, holiday programs and classroom activities that involve families

Open Monday - Friday
5:30 a.m. to 5:45 p.m.

For enrollment information or to schedule a family tour, contact the center at 606-324-9869. The Child Development Center is located at 2419 Lexington Avenue, Ashland, KY.

Pet Insurance

King's Daughters knows that pets are valued members of the family. This insurance covers everything from preventive care to accidents or illness, including costs of X-rays, office visits, medications, surgeries and hospital stays. You have the option of choosing your own vet or using a licensed in-network vet. Cost depends on your pet's age, species, and coverage level selected.

Work, Life, Balance

Team members may be eligible for paid time off, which can be used for vacation, holidays, short-term illness and/or injury, emergency situations or personal business. Team members should refer to King's Daughter's policies or bargaining unit agreement for additional information.

Education Assistance

King's Daughters is committed to helping its part-time and full-time team members pursue professional growth and development by offering education assistance for eligible courses. Contact Human Resources for program details.

529 College Savings Plan

Scholars Choice can help your family save for:

- college
- graduate school
- vocational school

Investing with Scholars Choice provides a number of advantages:

- professional money management
- favorable tax treatment
- significant flexibility

Sam's Club

The annual membership to Sam's Club is $50. This is payable over the first two payrolls of 2023. New memberships will receive a voucher in the mail to obtain their permanent ID card at the South Point Sam's Club location.

Additional Benefits

MASA Medical Transport Services Benefit

This benefit can cover out-of-pocket costs for any Emergency Air Ambulance, Emergency Ground Ambulance, Hospital to Hospital Ambulance or Repatriation to a Hospital Near Home, regardless of provider. The premium for this benefit is $6.47/pay period.

- **Emergency Air Ambulance Coverage –** MASA MTS covers out-of-pocket expenses associated with Emergency Air Ambulance transportation not to exceed $20,000 per occurrence to a medical facility for serious medical emergencies deemed medically necessary for the Insured and when the Insured Dependents require the same services.
- **Emergency Ground Ambulance Coverage –** MASA MTS covers out-of-pocket expenses associated with Emergency Ground Ambulance transportation not to exceed $20,000 per occurrence to a medical facility for serious medical emergencies deemed medically necessary for the Insured and when the Insured Dependents require the same services.
- **Hospital to Hospital Ambulance Coverage –** MASA MTS reimburses out-of-pocket expenses that the Insured and the Insured Dependents may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter, fixed-wing aircraft or ground ambulance.
- **Repatriation to Hospital Near Home Coverage –** MASA MTS provides services and covers out-of-pocket expense for the coordination of the Insured and the Insured Dependents' non-emergency transportation by a medically equipped air ambulance in the event of hospitalization more than one hundred (100) miles from the Insured's home if the treating physician and MASA MTS' Medical Director says it is medically appropriate and possible to transfer the Insured to a hospital nearer to home for continued care and recuperation.

COVERAGE BENEFIT	MAXIMUM BENEFIT LIMIT
Emergency Air Ambulance Coverage	$20,000, per event
Emergency Ground Ambulance Coverage	$20,000, per event
Hospital to Hospital Ambulance Coverage	Out-of-Pocket expenses
Repatriation to Hospital Near Home Coverage	Total Costs when arranged by MASA MTS

Disclaimers:
This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums and benefits vary depending on the benefits selected. For a complete list of benefits, premiums, and full terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your territory. MASA MTS products and services are not available in AK, NY, WA, ND, and NJ. MASA MTS utilizes third-party transportation service providers for all transportation services. MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation and an affiliated company with Medical Air Services Association, Inc., Medical Air Services Association of Florida, Inc., and MASA Insurance Services, Inc.
For IA, KY, PA, SC, and WV residents, MASA Insurance Services, Inc., with its principal place of business at 1250 S. Pine Island Road, Suite 500, Plantation, FL 33324, offers insurance coverage through Obsidian Insurance Company. Coverage is not available in all states and is subject to the company underwriting guidelines and the issued policy. Policy forms and policy terms may vary by state and territory. National Producer #19897480.
If the insured has a high deductible health plan that is compatible with a health savings account, benefits may become available under the MASA MTS policy for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once the Insured satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.
Maximum Benefit Amount pays a maximum of $20,000 per event for up to two (2) events per 12-month period for Emergency Air Ambulance and Emergency Ground Ambulance Coverage. Out-of-pocket expenses are paid for costs that remain after applying any primary insurance that needs to be paid for by the insured with personal financial resources covered explicitly under the Emergent Plus Insurance Policy for Hospital to Hospital coverage. Total costs are paid for Repatriation to Hospital Near Home Coverage when MASA MTS arranges the transportation service. Please refer to the Emergent Plus Transportation Services Insurance policy documents for complete details.
Maximum Benefit Amount pays out-of-pocket expenses that remain after applying any primary insurance that needs to be paid for by the insured with personal financial resources covered explicitly under the Emergent Plus Insurance policy for Emergency Ground Ambulance Coverage and Hospital to Hospital Ambulance Coverage. Total costs are paid for Repatriation to Hospital Near Home Coverage when MASA MTS arranges the transportation service. Please refer to the Emergent Plus Transportation Services Insurance policy documents for complete details.

Voluntary Identity Theft Protection

Identity theft monitoring can help prevent fraud, detect fraudulent activity daily and resolve any other identity theft issues you may face. The table below, only reflects some covered benefits. For a complete list of benefits, you may reach out to Human Resources and/or visit: https://www.guardwellid.com/cimap.php?id=premier

MEMBERSHIP LEVEL	LIFESTAGES	LIFESTAGES GOLD MONITORING	LIFESTAGES PLATINUM MONITORING
Monthly Premium	$4.95/month/ household	$6.96/month/ individual	$11.95/month/ individual
BENEFITS			
Complete Identity Theft Resolution	X	X	X
Proactive identity protection safeguards (including, but not limited to: document replacement services, child identity theft, tax & financial fraud support, social medial compromise assist, assisted living fraud support)	X	X	X
Worldwide 24/7/365 access to fraud specialists	X	X	X
Public records monitoring including SSN trace & change of address monitoring		X	X
Court records monitoring of all digital criminal records		X	X
Single bureau credit monitoring		X	
Single bureau credit report & score		X	
Triple bureau credit monitoring			X
Triple bureau report & score			X
Cyber surveillance monitoring for illegal use of personal information			X
Sex offender registry search & alert			X
Score tracker & monthly credit score			X

If there are any discrepancies between the information in this benefit guide and the Plan Documents, the Plan Documents will supersede.

AAA Group Membership

BENEFIT*	CLASSIC	PLUS	PREMIER
Mile Free per Tow	Up to 5 miles	Up to 100 miles	Up to 100 miles + One (1) tow up to 200 miles
Calls/yr/member	4	4	5
Passport Photos	Discounted Passport Photos	Discounted Passport Photos	Two (2) free sets of Passport Photos

ANNUAL PREMIUMS

CLASSIC PRIMARY	PLUS PRIMARY	PREMIER PRIMARY
$64.00	$105.50	$150.50
	AAA Plus/RV	AAA Premier/RV
	$165.50	$210.50

*Please see Human Resources for additional benefit information.

If there are any discrepancies between the information in this benefit guide and the Plan Documents, the Plan Documents will supersede.

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,300, your plan does not pay anything until you've paid $1,300 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance plan that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the plan's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified team member-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance plan to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance plan. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance plan. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which team members and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer team members to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from Ashland Hospital Corporation About Your Prescription Drug Coverage and Medicare under the Aetna Blue and White Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ashland Hospital Corporation 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. Ashland Hospital Corporation has determined that the prescription drug coverage offered by the Aetna Blue and White plan(s) 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 Ashland Hospital Corporation coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may 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 Ashland Hospital Corporation 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 at the end of these notices 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 Ashland Hospital Corporation 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 Medicare Part D 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:	January 1, 2023
Name of Entity/Sender:	Ashland Hospital Corporation
Contact—Position/Office:	Human Resources
Address:	2201 Lexington Ave. Ashland, KY 41101
Phone Number:	606-408-0028

Women's Health and 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 this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 606-408-0028.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 606-408-0028.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an team member, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Human Resources at 606-408-0028.

Kentucky Pregnant Workers Act (KPWA) Notification

On June 27, 2019, the provisions of the Kentucky Pregnant Workers Act ("KPWA") took effect for all Kentucky employers with 15 or more employees. The KPWA requires that employers provide employees with notice of this law and the protections it provides. The following notice is being provided to satisfy this requirement, but most importantly to assure you that King's Daughters remains committed to providing a supportive and affirming environment for all its employees, including those who become pregnant and work during pregnancy. We are pleased to continue supporting our employees during pregnancy, and will certainly comply with the new law. **This notice is provided for informational purposes and you are not required to respond in any way.**

The KPWA, (KRS 344.030 to 344.110), expressly prohibits employment discrimination in relation to an employee's pregnancy, childbirth, and related medical conditions. In addition, under the KPWA it is unlawful for an employer to fail to make reasonable accommodations for any employee with limitations related to pregnancy, childbirth, or a related medical conditions who requests an accommodation, including but not limited to:

(1) the need for more frequent or longer breaks;

(2) time off to recover from childbirth;

(3) acquisition or modification of equipment;

(4) appropriate seating;

(5) temporary transfer to a less strenuous or less hazardous position;

(6) job restructuring;

(7) light duty; modified work schedule;

(8) private space that is not a bathroom for expressing breast milk.

Please contact your Human Resources Department at 606-408-0022 if you have questions about this notice.

Important Contacts

MEDICAL
Aetna
866-987-0318
www.aetna.com

SUPPLEMENTAL HEALTH (Accident, Critical Illness, Hospital Indemnity)
MetLife
800- GET-MET8 (1-800-438-6388)
www.metlife.com

TELEMEDICINE
Aetna
855-TELADOC (835-2362)
Teladoc.com/Aetna

DENTAL
Delta Dental of KY
800-955-2030
www.deltadentalky.com
Policy #: M00143

VISION
Avesis
800-828-9341
www.avesis.com
Policy #: 30912-1143

HEALTH SAVINGS ACCOUNT
WEX
1-833-CALL-WEX (225-5939)
www.wexinc.com

FLEXIBLE SPENDING ACCOUNTS
WEX
1-833-CALL-WEX (225-5939)
www.wexinc.com

LIFE AND AD&D
Lincoln Financial
800-713-7384
www.mylincolnportal.com
Policy #: Life - SA3-850-290536-01

DISABILITY
Lincoln Financial
800-713-7384
www.mylincolnportal.com
Policy #:
STD: GD3-850-290536-01
LTD: GF3-850-290536-01

RETIREMENT
Empower
866-467-7756
empowermyretirement.com

BENEFICIARY ASSISTANCE
Lincoln Financial Group
888-628-4824

INTERNAL KDMC EAP PROGRAM
David Meade
606-408-4982
david.meade@kdmc.kdhs.us

IDENTITY THEFT
Guard Well Identity Theft Solutions
888-966-GUARD (4827)
https://www.guardwellid.com/cimap.php?id=premier

KING'S DAUGHTERS HUMAN RESOURCES
2000 Ashland Drive, Suite 100
Ashland, KY 41101-7005
606-408-0022

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KING'S
DAUGHTERS