

Questions on your benefits?

Visit the

Benefits Library

marshfieldclinic.org/careers/benefits-library



- Available 24/7 from work or home
- Resources available to help you learn about your options and enroll in Marshfield Clinic Health System benefits

Not able to attend benefits orientation? Check out orientation on demand. Visit www.marshfieldclinic.org/careers/orientation-demand

Workday



[https://wd5.myworkday.com/
marshfieldclinichealthsystems/d/home/html](https://wd5.myworkday.com/marshfieldclinichealthsystems/d/home/html)

- Access Workday mobile app anytime and anywhere
- Review your benefits, paid time off (PTO) and more.

Every Marshfield Clinic Health System's desktop has a direct link to the Benefits Library and Workday for your convenience

Check them out today!



Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Marshfield Clinic Health System, Inc.

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, benefit eligible Employees of the Employer regularly working a minimum of 20 hours per week working in the United States, who are citizens or permanent resident aliens of United States.

You will be eligible for coverage the first of the month following date of hire.

Your Spouse: Is eligible as long as you apply for and are approved for coverage yourself.

Your Child(ren): Is eligible as long as you apply for and are approved for coverage yourself.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of \$10,000	\$500,000	\$250,000
Spouse	Units of \$10,000	\$500,000	\$30,000
Children	Units of \$2,500	\$10,000	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:

Employee: 80% of your Term Life Insurance coverage amount or \$400,000, whichever is less.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Monthly Cost of Coverage:

Age	Employee Cost Per \$10,000 Unit	Spouse Cost Per \$10,000 Unit	Age	Employee Cost Per \$10,000 Unit	Spouse Cost Per \$10,000 Unit
0-19	\$0.600	\$0.600	60-64	\$9.200	\$9.200
20-24	\$0.600	\$0.600	65-69	\$15.400	\$15.400
25-29	\$0.600	\$0.600	70-74	\$30.600	\$30.600
30-34	\$0.800	\$0.800	75-79	\$30.600	\$30.600
35-39	\$0.900	\$0.900	80-84	\$30.600	\$30.600
40-44	\$1.000	\$1.000	85-89	\$30.600	\$30.600
45-49	\$1.860	\$1.860	90-94	\$30.600	\$30.600
50-54	\$3.740	\$3.740	95-99	\$30.600	\$30.600
55-59	\$6.000	\$6.000			

Child Cost Per \$2,500 Unit = \$0.200

Actual per pay period premiums may differ slightly due to rounding. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Monthly Cost:

Step 1: Use the chart above to find your **Monthly** rate based on your current age

Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.

Step 3: The result is the **Monthly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends — Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is hospital or home confined, receiving chemotherapy or radiation treatment, or disabled and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule — If you are still employed, your benefits and your spouse's benefits will reduce to 65% at age 65, 50% at age 70 and 35% at age 75.

Exclusions — Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.

Limitations — The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** — After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing evidence of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable evidence of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable evidence of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life Insurance are set forth in Group Policy No. FLX 967539. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

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MARSHFIELD CLINIC HEALTH SYSTEM, INC.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

We are pleased to announce that all benefit eligible employees can enroll themselves and/or their dependents in a Voluntary Accidental Death & Dismemberment program underwritten by Berkley Life & Health Insurance Company. Coverage applies on a 24 hour basis, 365 days a year, worldwide. Meaningful protection is available should you or your dependents suffer a covered Accidental Death, Dismemberment, Paralysis or Loss of Use of Limb.

ELIGIBILITY

Each benefit eligible employee may enroll in this plan.

You may also enroll Your eligible Dependents under the Family Plan. Eligible Dependents include Your legally married spouse, Your unmarried children under 20 years old and Your unmarried children at least 20 years old but less than age 26 who are: not regularly employed on a full-time basis; primarily dependent on You for support and maintenance; and attending an accredited college, university or other institution of higher learning or a vocational or licensed technical school on a full-time basis. You may not be covered as a Dependent and an employee at the same time.

For those who enroll, coverage will continue for as long as 12 months should You become disabled provided that premium continues to be paid. For other leave of absences approved by MCHS or temporary layoff, coverage will continue for up to 1 month provided premium payment continues.

Insurance takes effect on the first day of the month coinciding with or next following the date you complete your enrollment elections through the MCHS enrollment process. If you are not actively at work on the day your insurance would otherwise begin, coverage will become effective on the first of the month coinciding with or next following the date you return to active work.

BENEFIT AMOUNT (PRINCIPAL SUM)

You may purchase any amount from \$50,000 to \$1,000,000. Amounts from \$50,000 to \$500,000 are available in \$50,000 increments. Amounts greater than \$500,000 cannot exceed 10 x Your base annual salary and are available in \$100,000 increments.

Your Benefit Amount will remain in effect regardless of Your age. There is no benefit reduction upon attainment of age 70.

FAMILY COVERAGE

If You elect Family coverage, the Benefit Amount that applies to Your Dependents is a percentage of Your Benefit Amount (Principal Sum).

- **Spouse with no Dependent Children:** Your Spouse is covered for 60% of Your Principal Sum.
- **Spouse with Dependent Children:** Your Spouse is covered for 50% of Your Principal Sum and each Dependent Child is covered for 10% of Your Principal Sum up to \$75,000.
- **Dependent Children (and no Spouse covered)** will be covered for 15% to a maximum of \$75,000.

PREMIUM

Your cost for this insurance is based on a rate of .03 per thousand per month for the Employee Only Plan and a rate of .045 per thousand per month for the Family Plan. This means that the options and costs available to You are as follows:

BENEFIT SELECTION	YOUR MONTHLY COST FOR THE EMPLOYEE ONLY PLAN	YOUR MONTHLY COST FOR THE FAMILY PLAN
\$50,000	\$1.50	\$2.25
\$100,000	\$3.00	\$4.50
\$150,000	\$4.50	\$6.75
\$200,000	\$6.00	\$9.00
\$250,000	\$7.50	\$11.25
\$300,000	\$9.00	\$13.50
\$350,000	\$10.50	\$15.75
\$400,000	\$12.00	\$18.00
\$450,000	\$13.50	\$20.25
\$500,000	\$15.00	\$22.50
*\$600,000	\$18.00	\$27.00
*\$700,000	\$21.00	\$31.50
*\$800,000	\$24.00	\$36.00
*\$900,000	\$27.00	\$40.50
*\$1,000,000	\$30.00	\$45.00

**You may only select these amounts if it does not exceed 10 times Your salary.*

BENEFITS PROVIDED

ACCIDENTAL DEATH AND DISMEMBERMENT

Should a Covered Person suffer an Injury resulting in any of the Covered Losses shown below, within 365 days of the Covered Accident, You or Your beneficiary will receive the percentage of the Principal Sum shown below for that loss. If multiple losses from the same Covered Accident occur, only one Benefit, the largest, will be paid.

SCHEDULE OF COVERED LOSSES

<u>LOSS OF</u>	<u>BENEFIT</u> (Percent of Principal Sum)
Life	100%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	75%
Paraplegia	75%
Uniplegia	25%
Thumb and Index Finger of the Same Hand	25%
Four Fingers of the Same Hand	25%

WHAT'S NOT COVERED (EXCLUSIONS)

No benefits are payable for losses resulting from:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
6. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - ii. While being used for any test or experimental purpose; or
 - iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or

Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.

BENEFICIARY DESIGNATION

Benefits for Your loss of life will be payable to the beneficiary or beneficiaries designated in writing by You and on file with MCHS; otherwise, the beneficiary will be the person designated under the Group Life Policy issued to MCHS. If none is designated, the beneficiary will be the first in the following order: a) Spouse; b) Your Children; c) Your parents; d) Your estate.

A Dependent's beneficiary is the Insured Employee.

IMPORTANT INFORMATION

This summary provides a brief description of coverage provided under policy form series AH51051, underwritten by Berkley Life and Health Insurance Company (domiciled in Iowa - California Certificate of Authority #08527) and/or StarNet Insurance Company (domiciled in Delaware - California Certificate of Authority #6978) 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690 and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy for complete details. Coverage terms, conditions, limitations and exclusions may vary or may not be available in all states. Please see the policy for complete details or contact us at SpecialRiskSolutions@BerkleyAH.com. Coverage does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from offering or providing insurance.

The insurance described in this document provides limited benefits. Limited benefit plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential coverage as set forth under the Patient Protection and Affordable Care Act.

Premium Rates (Level 1) 30+ Hours/week

Plan year: April 1, 2020 – March 31, 2021

Health Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
Active Advantage POS				
Single	101.23	202.46	562.26	764.72
Employee +1	202.47	404.94	1,124.52	1,529.46
Employee + Children	214.52	429.04	1,181.82	1,610.86
Family	233.91	467.82	1,307.64	1,775.46
Active Advantage Indemnity				
Single	210.33	420.66	562.26	982.92
Employee +1	420.66	841.32	1,124.52	1,965.84
Employee + Children	453.89	907.78	1,181.82	2,089.60
Family	489.15	978.30	1,307.64	2,285.94
Active Advantage HMO				
Single	82.40	164.80	562.26	727.06
Employee +1	164.79	329.58	1,124.52	1,454.10
Employee + Children	174.84	349.68	1,181.82	1,531.50
Family	190.17	380.34	1,307.64	1,687.98
High Deductible Health Plan POS (\$3000/\$6000)				
Single	64.82	129.64	562.26	691.90
Employee +1	129.64	259.28	1,124.52	1,383.80
Employee + Children	136.27	272.54	1,181.82	1,454.36
Family	150.72	301.44	1,307.64	1,609.08
High Deductible Health Plan Indemnity (\$3000/\$6000)				
Single	124.80	249.60	562.26	811.86
Employee +1	249.60	499.20	1,124.52	1,623.72
Employee + Children	265.70	531.40	1,181.82	1,713.22
Family	288.56	577.12	1,307.64	1,884.76
High Deductible Health Plan HMO (\$3000/\$6000)				
Single	47.78	95.56	562.26	657.82
Employee +1	95.55	191.10	1,124.52	1,315.62
Employee + Children	100.44	200.88	1,181.82	1,382.70
Family	111.08	222.16	1,307.64	1,529.80



**Marshfield Clinic
Health System**

Premium Rates (Level 2) 20 – 29.9 Hours/week

Plan year: April 1, 2020 – March 31, 2021

Health Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
Active Advantage POS				
Single	178.97	357.94	406.78	764.72
Employee +1	357.95	715.90	813.56	1,529.46
Employee + Children	376.99	753.98	856.88	1,610.86
Family	415.51	831.02	944.44	1,775.46
Active Advantage Indemnity				
Single	288.07	576.14	406.78	982.92
Employee +1	576.14	1,152.28	813.56	1,965.84
Employee + Children	616.36	1,232.72	856.88	2,089.60
Family	670.75	1,341.50	944.44	2,285.94
Active Advantage HMO				
Single	160.14	320.28	406.78	727.06
Employee +1	320.27	640.54	813.56	1,454.10
Employee + Children	337.31	674.62	856.88	1,531.50
Family	371.77	743.54	944.44	1,687.98
High Deductible Health Plan POS (\$3000/\$6000)				
Single	142.56	285.12	406.78	691.90
Employee +1	285.12	570.24	813.56	1,383.80
Employee + Children	298.74	597.48	856.88	1,454.36
Family	332.32	664.64	944.44	1,609.08
High Deductible Health Plan Indemnity (\$3000/\$6000)				
Single	202.54	405.08	406.78	811.86
Employee +1	405.08	810.16	813.56	1,623.72
Employee + Children	428.17	856.34	856.88	1,713.22
Family	470.16	940.32	944.44	1,884.76
High Deductible Health Plan HMO (\$3000/\$6000)				
Single	125.52	251.04	406.78	657.82
Employee +1	251.03	502.06	813.56	1,315.62
Employee + Children	262.91	525.82	856.88	1,382.70
Family	292.68	585.36	944.44	1,529.80



**Marshfield Clinic
Health System**

Spousal Or Domestic Partner Surcharge For Health Insurance

Does your spouse or domestic partner have access to health insurance through their employer?

- ☐ Yes
- ☐ No

If your answer to this question is yes, and they are or will be enrolled on your health insurance plan through Marshfield Clinic Health System, your premium will include a \$100 per month spousal or domestic partner surcharge. You are responsible for maintaining this eligibility status in Workday on the Benefits/Change Dependents event. This surcharge does not show up on your paycheck as a separate/ line item, but is included in your health insurance premium.

Please note: If you have a qualifying life changing event that makes this surcharge no longer applicable, it is your responsibility to make the change in Workday within 31 days of the life event so the surcharge stops being applied to your premium. No retro reimbursements are made for Workday changes that are made outside the 31 days window.

You may qualify for a waiver of this surcharge

Does your spouse or domestic partner work for Marshfield Clinic Health System?

- ☐ Yes
- ☐ No

If your answer to this question is yes, the surcharge will be waived. You are responsible for maintaining this eligibility status in Workday on the Benefits/Change Dependents event.

Do you think you qualify for the waiver based on the federally designated guidelines?

- ☐ Yes
- ☐ No

If your answer to this question is yes, please contact the Patient Assistance Center at **PACCounselorShared@marshfieldclinic.org** to find out if you qualify based on the guidelines designated by the federal government. Please note that you will need to provide a copy of your 2019 federal tax return to the PAC to verify qualification for the waiver.



Marshfield Clinic
Health System

Benefit Plan Eligibility & Definitions

Life Changing Events

Benefits eligible: Employees budgeted at 50% full time equivalent or greater and not in a temporary status are benefit eligible.

Effective date: First of the month following benefit eligibility or hire date, assuming enrollment has been completed within 31 days.

- Deductions are taken from the first two paychecks in the month; 24 paychecks per year.
- Total monthly cost also is the COBRA continuation rate.

Dependent Definition

Spouse

A spouse is a husband or wife through a legal union (marriage).

Domestic Partner

A domestic partner is an eligible dependent who has met the criteria of declaring a domestic partnership with the employee. In order to determine if a person qualifies as a domestic partner, the employee must submit a declaration of domestic partnership form to Human Resources (HR). This form can be found on the benefits library and must be approved by HR prior to the employee electing health and/or dental insurance coverage for the domestic partner.

Child

- A son, daughter, step-child of the employee, legal ward, a legally adopted individual of the employee or an individual who is lawfully placed with the employee for legal adoption by the employee.

Children are covered from birth through the end of the month they turn age 26 regardless of their student, financial, access to other coverage or marital status.
- A grandchild of the employee. Health insurance coverage only continues until the dependent child (as described above) is 18 years of age.

Life Changing Events

A life changing event is a change in status, family or work, that allows you to make changes to some or all insurance plans without being subject to Internal Revenue Service or master plan contract restrictions or limitations.

In most situations, you have a 31-day period from the event to complete the necessary changes in Workday. After 31 days, restrictions/limitations will either not allow you to make changes, or require you to wait until the next scheduled open enrollment.

Switch Between Plans: Within 31 days of a life changing event or each year during the annual benefit re-enrollment period, health and/or dental plan participants have the option to switch to one of the other Marshfield Clinic Health System group health/dental plans. The effective date will be the first of the month following the date of the life changing event or the annual open enrollment effective date. For this purpose, life changing events include: marriage, divorce, birth/adoption, death, dependent losing or re-acquiring eligibility, spouse/dependent moving into or out of the POS service area, termination or loss of other coverage, court order, reaching lifetime limits or exhausting COBRA.

If you have questions regarding what constitutes as a qualifying life changing event, please contact Human Resources at: **715-387-5254** or ext. **7-5254**.



Marshfield Clinic Health System

Special Enrollment Rights Notice

Federal Law (called HIPAA) requires that we tell you about a very important provision in the plan, your right to enroll under “special enrollment provisions” if you acquire a new dependent, or if you or an eligible dependent decline coverage under this plan because of alternative coverage and later such coverage terminates.

Special enrollment provisions

Rule #1 - Loss of other coverage.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage and indicate that reason in writing when declining coverage, you may be able to enroll yourself and/or your dependents in this plan should the other coverage terminate or employer contributions for that coverage terminate. However, you must request enrollment within 31 days after you or your coverage ends or employer contributions stop, and meet certain other conditions described in your group policy.

This rule also includes people who request enrollment under the plan within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus or Children’s Health Insurance Program (CHIP); or people who request enrollment under the plan within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus or CHIP has been determined.

Rule #2 - Marriage, birth or adoption.

In addition, if you have a new dependent as a result of marriage, birth adoption or placement for adoption, you might be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, and that you meet certain other important conditions described in your group policy. (Under Wisconsin law, additional time for enrollment is available for certain situations: notice of a newborn shall be given as soon as possible and within one year, and notice of adopted child shall be given within 60 days of adoption or placement.)

To request special enrollment or to obtain more information, contact your employer.

Marshfield Clinic Health System, Inc.

Health Insurance Benefits Effective 4/1/20

HDHP \$3,000/\$6,000 HMO, POS and Indemnity

Starting April 1, 2020, a third option will be available for the Active Advantage and HDHP medical plans. This third option is a HMO plan that does not have any out-of-network coverage.

HMO = HMO network includes Marshfield Clinic Health System providers and facilities along with other select providers. There is no out of network coverage with this plan. A complete list of HMO providers and facilities can be found at: www.securityhealth.org

POS = Point of Service in-network coverage includes Marshfield Clinic Health System providers and facilities along with other select providers. A complete list of in-network providers can be found at: www.securityhealth.org

Indemnity = No network restrictions

	HMO, POS In-network or Indemnity Coverage	POS Out-of-network
Deductible: (amount you pay before the health insurance begins to pay)	\$3,000 Single \$6,000 Family	\$6,000 Single \$12,000 Family
Coinsurance: (you pay a portion of the billed charge and the health insurance pays the rest)	0%	20%
Out-of-Pocket Limits (Deductible and Coinsurance ONLY)	\$3,000 Single \$6,000 Family	\$8,000 Single \$16,000 Family
Emergency Room Services**	\$200 Copay then Subject to Deductible	\$200 Copay then Subject to In-network Benefits
Office Visits	Subject to Deductible	Subject to Out-of-Pocket Limits
Preventive Services	Covered 100% (see page 3 for covered services)	Subject to Out-of-Pocket Limits
Maximum Out-of-Pocket: (includes the Out-of-Pocket Limit, emergency room copays and pharmacy copays/coinsurance)	\$5,000 Single \$10,000 Family	\$10,000 Single \$20,000 Family

**Emergency Services are subject to in-network deductibles and copays. Emergency room copays are waived only if admitted inpatient. Observation stays, although within the hospital, are considered outpatient.

Medical Benefits: Important information about your medical benefits:

- This is a qualified HDHP and you may contribute to an HSA account with this plan.
- If one person on your family plan meets their \$3,000 deductible they will only pay non-preventive prescription copays/coinsurance and emergency room copays until the end of the plan year or until they reach the maximum out-of-pocket. If any combination of the family meets the \$6,000 deductible the entire family deductible is met regardless of how many individuals are in your family. Prescription copays/coinsurance and emergency room copays will continue until the end of the plan year or until the maximum out-of-pocket has been met.
- Out-of-pocket costs with an out-of-network provider will be applied to the in-network limit. In-network costs will NOT apply to the out-of-network limit.

You are responsible for the full cost of non-preventive pharmacy expenses until your deductible has been met. Please refer to the pharmacy benefits section for additional information regarding how pharmacy benefits apply.

Active Advantage HMO, POS and Indemnity

HMO = HMO network includes Marshfield Clinic Health System providers and facilities along with other select providers. There is no out of network coverage with this plan. A complete list of HMO providers and facilities can be found at: www.securityhealth.org

POS = Point of Service in-network coverage includes Marshfield Clinic Health System providers and facilities along with other select providers. A complete list of in-network providers can be found at: www.securityhealth.org

Indemnity = No network restrictions

	HMO, POS In-network or Indemnity Coverage	POS Out-of-network
Deductible: (amount you pay before the health insurance begins to pay)	\$1,300 Single \$2,600 Family	\$2,600 Single \$5,200 Family
Coinsurance: (you pay a portion of the billed charge and the health insurance pays the rest)	20%	40%
Out-of-Pocket Limits (Deductible and Coinsurance ONLY)	\$2,500 Single \$5,000 Family	\$5,000 Single \$10,000 Family
Emergency Room Services**	\$200 Copay then subject to deductible/coinsurance	\$200 Copay then subject to in-network benefits
Office Visits	2 office visits per benefit year for problem-related services covered 100%. Must be with a primary care provider.* Additional subject to Out-of-Pocket Limits	Subject to Out-of-Pocket Limits
Preventive Services	Covered 100% (see page 3 for covered services)	Subject to Out-of-Pocket Limits
Maximum Out-of-Pocket: (includes the Out-of-Pocket Limit, emergency room copays and pharmacy copays/coinsurance)	\$6,550 Single \$13,100 Family	\$13,100 Single \$26,200 Family
Chronic Care Services for Diabetes, Asthma and High Blood Pressure	100% coverage for some services. See Schedule of Benefits for details	Subject to Out-of-Pocket Limits

* **Primary care providers** include family practice, internal medicine, obstetrics/gynecology (OB/GYN) and pediatrics.

* When at all possible, participants are encouraged to use the Care My Way nurseline and/or urgent care services.

**Emergency Services are subject to in-network deductibles and copays. Emergency room copays are waived only if admitted inpatient. Observation stays, although within the hospital, are considered outpatient.

Medical Benefits: Important information about your medical benefits:

- This is NOT a qualified HDHP. You cannot have an HSA account with this plan.
- This plan covers two problem-related office visits billed by a primary care provider each plan year for each member in your family.
- Out-of-pocket costs with an out-of-network provider will be applied to the in-network limit. In-network costs will NOT apply to the out-of-network limit.

Preventive Care

Your preventive benefit as shown in your Schedule of Benefits	Frequency limit/coverage
Preventive benefit Please refer to the Security Health Plan wellness guide at www.securityhealth.org/preventive-care for recommendations on frequency of preventive services.	Not applicable
<ul style="list-style-type: none"> Comprehensive physical examination (complete physical) <ul style="list-style-type: none"> Well-baby care Well-child care Adolescent well Adult well-care 	Covered at 100%
<ul style="list-style-type: none"> Gynecological examination (breast exam and pelvic exam) 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Digital prostate examination 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Preventive hearing test 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Comprehensive preventive vision examination 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Mammogram to screen for breast cancer 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Pap smear to screen for cervical cancer 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Colonoscopy screening for colorectal cancer Sigmoidoscopy for colorectal cancer 	One every 5 years, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Other screenings for colorectal cancer <ul style="list-style-type: none"> Fecal occult blood testing 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Screening laboratory services Including, but not limited to: basic metabolic panel, breast cancer genetic testing, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), pediatric lead poisoning screening, prostate specific antigen (PSA), and urinalysis 	Each laboratory service covered at one per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Bone mineral density (dexa) scan to screen for osteoporosis 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Chlamydia screening 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Ultrasound for screen of an abdominal aortic aneurysm 	One per calendar year, then subject to deductible/coinsurance
<ul style="list-style-type: none"> Breast feeding support and counseling. 	Covered at 100%

The Affordable Care Act (ACA) makes certain preventive drugs available to you at \$0:	Coverage
<ul style="list-style-type: none"> Aspirin Fluoride supplements Folic acid supplements Vitamin D Supplements Smoking Cessation products Bowel preparation products Statins Oral contraceptives Breast cancer prevention drugs Vaccines 	Covered at 100%

*ACA restrictions apply

If you have one of the Point of Service (POS) plans, Preventive Care benefits are only available with in-network providers.

Pharmacy Benefits

	MCHS pharmacy	Other pharmacies
Tier 1 Includes preferred generic drugs	\$5 copay per 1-month supply	\$10 copay per 1-month supply
Tier 2 Includes non-preferred generic drugs and preferred name brand drugs	\$30 copay per 1-month supply	\$50 copay per 1-month supply
Tier 3 Includes costly, non-preferred generic drugs and non-preferred brand drugs. In most cases, there are preferred alternatives on a lower tier.	\$60 copay per 1-month supply	Member pays the greater of \$100 or 50% with no maximum
Tier 4 Includes specialty drugs and some very high cost brand/generic drugs. Specialty drugs are generally high cost, treat rare conditions, and require special handling, in-depth patient education, and continuous monitoring.	25%	For limited distribution drugs which are only available through select pharmacies, 25% coinsurance will be assessed.
Additional Benefits		
Maintenance Drugs	Receive a 90-day supply of drugs with only 2-1/2 copays	One time fill
Preventive Drug List	Covered at 100%	Subject to copay
Diabetes Drugs and supplies: Includes coverage for formulary insulin, testing supplies and oral prescription drugs. Formulary list: www.securityhealth.org/prescription-tools	Covered at 100%	Covered at 100%

You must use a MCHS pharmacy for maintenance, preventive and specialty drugs.

Additional information regarding these plans can be obtained upon request by contacting the Benefits Department of Marshfield Clinic Health System at mcl.hr.benefits@marshfieldclinic.org

Please note that this is a summary of benefits offered and that if there are any discrepancies between this document and the official Plan Document, the Plan Document overrules all other documents at all times.



**Marshfield Clinic
Health System**

Health Insurance Network Definitions

Effective April 1, 2020, Marshfield Clinic Health System is offering HMO options for the Active Advantage and HDHP health insurance plans.

Under an HMO network, coverage is available to you and your covered family members from in-network providers. You can find a list of the in-network providers on the website at www.securityhealth.org/directory. Coverage is available under the HMO option if the health care provider and the facility are in network.

HMO Coverage

If you have HMO coverage, you must receive care from an in-network provider.

Benefits are not available for services received from out-of-network providers except in very limited circumstances. Example below:

- A service that you seek which might not be available from any in-network provider. In this situation, a network provider might refer you to or suggest that you go to an out-of-network provider.
 - You will need to contact Security Health Plan (SHP) before receiving care from an out-of-network provider.
 - SHP will provide a written decision on whether your services from an out-of-network provider will be covered.
 - If SHP does approve those services, those claims will be processed based on the usual, customary and reasonable (UCR) fee schedule for out of-network providers. This means that the out-of-network provider would be paid as if they were an in network provider and any amount over that would be your responsibility.
 - The HMO option will offer the lowest cost for employees for services received from MCHS providers and facilities.
- Referrals
 - A recommendation or referral by an in-network health care provider to receive services from an out-of-network health care provider is not covered unless prior authorized by SHP

or otherwise stated in a member's Schedule of Benefits. Please have your health care provider contact SHP before you receive non-emergency or non-urgent services from out-of-network health care providers.

Point of Service Coverage (POS)

If you are covered by a POS health insurance network, you have in-network and out-of-network coverage and benefits.

- The reimbursement or benefit you receive varies depending on the provider.
- You have the lowest out-of-pocket cost when you receive care from in-network providers at in-network facilities.
- You have higher out-of-pocket costs when you use out-of-network providers and facilities. Claims processed for out-of-network providers and facilities are based on the UCR fee schedule, which means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.

Indemnity Coverage

If you are covered by an Indemnity health insurance network, you can choose to receive care from any in-network provider or out-of-network provider.

- Claims processed for out-of-network providers and facilities are based on the UCR fee schedule, which means your out-of-pocket costs will likely be higher for services you receive from out-of-network providers.



Urgent/emergent-all health insurance plan options (same as current benefit)

Urgent/emergent care is covered subject to applicable benefit limitations, deductible, coinsurance and copayment amounts.

([Review this information](#) when seeking urgent and emergent care services.)

Medical emergency definition:

A condition with acute symptoms of sufficient severity, including severe pain, that with lack of medical attention would likely result in:

- Serious jeopardy to the participant's health.
- Serious impairment to the participant's bodily functions.
- Serious dysfunction of one or more of the participant's body organs or parts.

Urgent care definition:

Care that is needed sooner than a routine doctor's visit and does not meet the criteria for medical emergency. It is not follow-up care, unless such care is necessary to prevent the member's health from becoming significantly worse before reaching a participating provider.

Get convenient care without leaving home or work:

[Review this information about](#) Care My Way services that are available in Wisconsin, Minnesota and Michigan.



Marshfield Clinic Health System

Get convenient care *without* leaving home or work

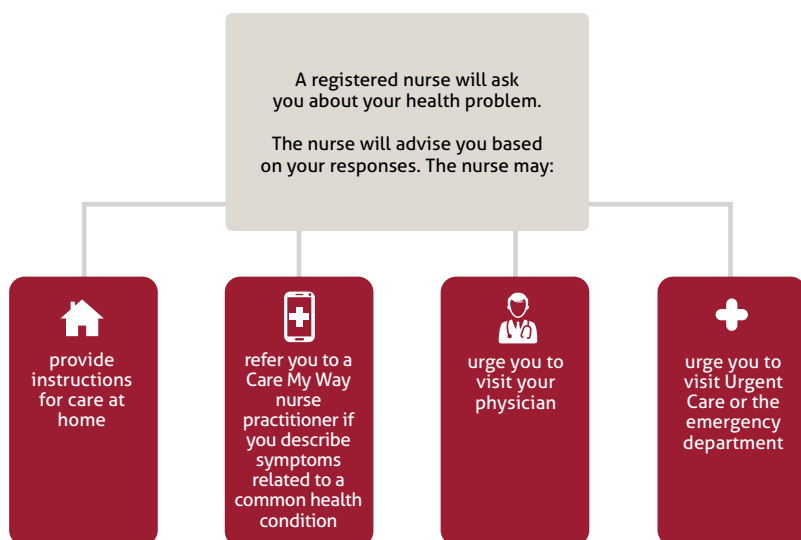


You have a 103° fever.



Start by calling our 24-hour Nurse Line.

Call 1-800-549-3174 (TTY: 711)



*Our 24-hour Nurse Line is available seven days a week, including holidays.

24-hour Nurse Line

If you need to talk to a provider after hours, you may call the provider's office. You may also call Security Health Plan's 24-hour Nurse Line at **1-800-549-3174**, seven days a week, including holidays, to connect with a registered nurse who can help answer your health care questions. The registered nurse will provide advice for seeking care or instructions for care at home.

Care My Way®

Symptoms of certain minor illnesses can be all too familiar, but a trip to the doctor's office can take time and energy you don't have. Call Care My Way instead. For many common health conditions, you can talk to one of our nurse practitioners by phone, or try a virtual visit by downloading the app. The nurse can verify your symptoms and, if needed, call a prescription into the network pharmacy of your choice – saving you time and hassle. Care My Way has no copay, no deductible charge and unlimited visits*. For a complete list of conditions Care My Way can treat, and more information about the service, go to: www.securityhealth.org/CareMyWay.

Care My Way services are available in Wisconsin, Minnesota and Michigan.

*Security Health Plan is not responsible for any tax-related charges for HSA plans.

Seeking care after hours



Using urgent care services

Sometimes you need care quickly when you are outside the Security Health Plan service area. If you cannot safely postpone care until you return to the service area, you may receive care at the nearest appropriate medical facility. When within the Security Health Plan service area, you must use in-network providers. Notify Security Health Plan as soon as reasonably possible of any services received from a non-network provider.



Using emergency care services

When you need emergency services, whenever possible use in-network hospital emergency rooms. If you are unable to reach a network provider, go to the nearest appropriate medical facility. If you go to a non-network provider for care, you should notify Security Health Plan of where you received emergency care as soon as possible.



If you have an emergency,
call 911

What will it cost me?

Average cost of most common visits in Wisconsin*

Upper respiratory infection



 vs 
\$184 **\$689**


Pink Eye



 vs 
\$175 **\$673**

Sinusitis



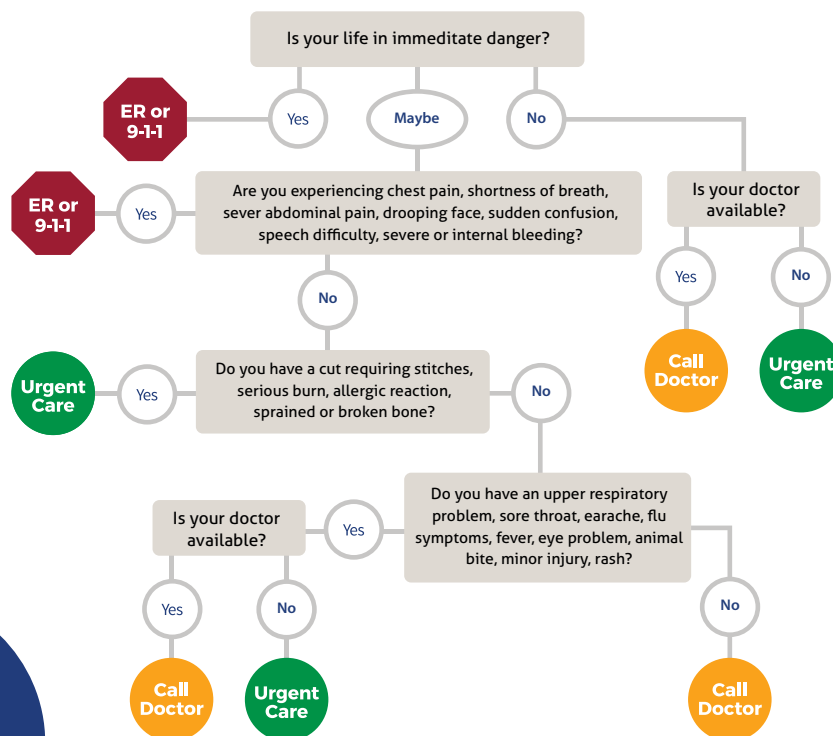
 vs 
\$183 **\$842**

Sore Throat



 vs 
\$242 **\$959**

How should I choose?



* Based on 2018 claims data from Security Health Plan

Dental Benefit Comparison & Premium Rates

Participants may enroll within 31 days from a start/benefit eligibility date or life changing event. Participants may switch between plans during the annual enrollment period; effective April 1. Participants who enroll during the annual enrollment period will be eligible for diagnostic/preventive services only for the first 12 months.

This benefit comparison does not include all exclusions or limitations to the policies. Marshfield Clinic Health System, individually or together with its insurers, reserves the right to revise, supplement, or rescind the policies and benefits described herein from time to time as it deems appropriate, in its sole and absolute discretion. Employees will be notified of changes to the policies or benefits through email and on-line publications.

Delta Dental Plan

Choice of dentists: May choose any dentist. Reimbursement subject to Delta Dental's Maximum Plan Allowance. (www.deltadentalwi.com, then select Delta Dental PPO or Premier)

Deductible: Single \$40/plan year Family \$120/plan year
Note: Deductible not applicable to diagnostic or preventive services.

Annual maximum: \$1,500/plan year (per person)
(Does not include orthodontia)

Diagnostic/preventive | Covered at 100%

Dental X-rays	Oral exams and cleanings	Fluoride application	Space maintainers
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Regular restorative | Covered at 80%

Emergency treatment for pain	Amalgam/composite restorations	Stainless steel crowns	Endodontics (root canals) Periodontics
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Special restorative | Covered at 80%

Inlays	Onlays	Jackets	Crowns
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Prosthetics | Covered at 80%

Bridges	Partials	Dentures	Repairs/adjustment
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Orthodontics

Appliances/treatment (no age limit, available to children and adults)
Insurance pays 80% of cost up to a \$2,000 lifetime limit. Remaining cost is the responsibility of the patient.

Dental Com Plan

Choice of dentists: May choose from among the Dental Clinic of Marshfield, S.C. dentists only located in Marshfield, Neillsville and Stratford, Wisconsin.			
Deductible: \$0 Note: Coinsurance and lab fees must be paid in full on day of service.			
Annual maximum: No Annual Maximum			
Diagnostic/preventive Covered at 100%			
Dental X-rays	Oral exams and cleanings	Fluoride application	Space maintainers
Regular restorative Covered at 90%			
Emergency treatment for pain	Amalgam/composite restorations	Stainless steel crowns	Endodontics (root canals) Periodontics
Special restorative Covered at 90% except lab*			
Inlays	Onlays	Jackets	Crowns
Prosthetics Covered at 90% except lab*			
Bridges	Partials	Dentures	Repairs/adjustment
Orthodontics			
Appliances/treatment (no age limit, available to children and adults) Patient pays 50% of cost until patient has paid \$2,500, then insurance covers 100% of remaining cost			

*Dental laboratory charges are defined to be those actual costs (materials and labor) for making or repairing any prosthetic device (such as bridges, dentures or crowns). Laboratory charges can vary by procedure.

Premium Rates (Level 1) 30+ Hours/week

Plan year: April 1, 2020 – March 31, 2021

Dental Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
Delta Dental Plan				
Single	6.68	13.36	24.80	38.16
Employee +1	13.35	26.70	49.62	76.32
Employee + Children	16.21	32.42	60.19	92.61
Family	25.07	50.14	93.14	143.28
Dental Com Plan				
Single	6.92	13.83	25.69	39.52
Employee +1	13.74	27.48	51.05	78.53
Employee + Children	17.15	34.30	63.70	98.00
Family	24.72	49.44	91.81	141.25

Premium Rates (Level 2) 20 – 29.9 Hours/week

Plan year: April 1, 2020 – March 31, 2021

Dental Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
Delta Dental Plan				
Single	10.26	20.52	17.64	38.16
Employee +1	20.53	41.06	35.26	76.32
Employee + Children	24.91	49.82	42.79	92.61
Family	38.54	77.08	66.20	143.28
Dental Com Plan				
Single	10.63	21.26	18.26	39.52
Employee +1	21.12	42.24	36.29	78.53
Employee + Children	26.36	52.72	45.28	98.00
Family	38.00	76.00	65.25	141.25



**Marshfield Clinic
Health System**

Health Insurance Marketplace Notice

To: Marshfield Clinic Health System
Physicians and Staff

From: Human Resources, Benefits Manager

Subject: Health Insurance Marketplace Notice

The following is a required notice.

Health Care Reform requires the distribution of the enclosed notice to all active physicians and staff. The enclosed notice provides general information about the Health Insurance Marketplace.

The enclosed notice is personalized based on your eligibility for benefits with Marshfield Clinic Health System, as of the date of distribution.

Please review the Notice. (The Notice begins on the back of this memo.)



**Marshfield Clinic
Health System**



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Office, Benefits Representative 715-387-5254.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Marshfield Clinic Health System, Inc.		4. Employer Identification Number (EIN) 49-1495343	
5. Employer address 1000 North Oak Ave		6. Employer phone number 715-387-5254	
7. City Marshfield	8. State WI	9. ZIP code 54449	
10. Who can we contact about employee health coverage at this job? Human Resources Office, Benefits Representative			
11. Phone number (if different from above) 715-387-5254		12. Email address mcl.hr.benefits@marshfieldclinic.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Scheduled to work 30+ hours per week

Scheduled to work 20+ hours per week for a period greater than six months

Americorp Members excluded

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

A son, daughter, step-child of the employee, legal ward, legally adopted individual of the employee or an individual who is lawfully placed with the employee for legal adoption by the employee. Covered from birth through the end of the month they turn age 26.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$1165.56 (2019)

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☒ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? 04/01/2020

☐ Employer won't offer health coverage

☒ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$1146.72

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☒ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/pi/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Important Notice from Marshfield Clinic Health System, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Marshfield Clinic Health System, Inc. (MCHS) 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:

- 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.
- MCHS has determined that the prescription drug coverage offered by Active Advantage and High Deductible Health Plan (HDHP) \$3000/\$6000 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 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 15 to December 7.

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 Active Advantage and HDHP \$3000/\$6000 coverage will not be affected. Active Advantage and HDHP \$3000/\$6000 coverage will coordinate benefits with your Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Active Advantage or HDHP \$3000/\$6000 coverage, be aware that you and your dependents may not be eligible 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 MCHS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCHS changes. You also may request a copy of this notice at any time.

Remember:

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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)**.

Sender and contact is:

Marshfield Clinic Health System, Inc.
Human Resources, Benefits Manager
1000 N. Oak Avenue
Marshfield, WI 54449

**715-387-5254 or
1-800-782-8581, ext. 7-5254**



**Marshfield Clinic
Health System**

Continuation Coverage Rights Under COBRA

(General Notice)

Introduction

You are receiving this notice because you are eligible for or have recently become covered under a Marshfield Clinic Health System group health and/or dental plan(s). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health and/or dental coverage. **This notice provides a general explanation of continuation coverage as to when it may become available to you and your family and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and federal law, you should either review the benefit Plan's Summary Plan Description or get a copy of the Plan document from the Plan administrator.

The Plan administrator is
Marshfield Clinic Health System,
Human Resources, benefits manager
1000 N. Oak Avenue
Marshfield WI 54449,
715-387-5004

The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA continuation coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "life changing event." Specific life changing events are listed later in this notice. COBRA continuation coverage must be offered to each person under the Plan because of a life changing event. Depending on the type of life changing event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following life changing events happens:

- Your hours of employment are reduced.
- You are engaged in active military service for more than 31 days.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following life changing events:

- Your spouse dies.
- Your spouse is engaged in active military service for more than 31 days.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both).

- You become divorced from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a life changing event even though the ex-spouse lost coverage earlier; if the ex-spouse notifies the administrator within 60 days after the divorce and can establish that the employee canceled the coverage earlier in anticipation of the divorce, then COBRA coverage may be available for the period after the divorce.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because one of the following life changing events happens:

- The parent-employee dies.
- The parent-employee is engaged in active military service for more than 31 days.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parents become divorced.
- The child stops being eligible for coverage under the plan as a "dependent child".
- The parent employee becomes entitled to Medicare benefits (Part A, Part B, or both).

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a life changing event. If a proceeding in bankruptcy is filed with respect to Marshfield Clinic Health System, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Your responsibility

For life changing events (divorce of the employee and spouse, employee becoming entitled to Medicare benefits, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources, benefits manager. The Plan requires you to notify the benefits manager within 60 days after the life changing event occurs. Notification may be submitted in writing, person or by direct telephone contact (messages not acceptable) to Marshfield Clinic Health System Human Resources, benefits manager.

Once the benefits manager receives notice that a life changing event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the Plan coverage would otherwise have been lost.

If you or your spouse or dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the life changing event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. Continuation coverage lasts for up to 24 months in the event of active military service.

When the qualifying event is the end or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the

date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

There are two ways in which the COBRA continuation coverage can be extended.

1. Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the benefits manager in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the benefits manager is notified of the Social Security Administration's determination and before the end of the 18-month period of COBRA continuation coverage.

This notice should be sent to

Marshfield Clinic Health System,
Human Resources, benefits manager
1000 N. Oak Avenue
Marshfield WI 54449

2. Second life changing event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the benefits manager is notified of the second life changing event within 60 days of the second life changing event.

This notice should be sent to

Marshfield Clinic Health System,
Human Resources, benefits manager
1000 N. Oak Avenue
Marshfield WI 54449

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Plan informed of address changes

In order to protect your family's rights, you should keep Human Resources informed of any changes in the addresses of family members.

You should also keep a copy, for your records, of any notices you send to the Marshfield Clinic Health System, Human Resources, benefits manager
1000 N. Oak Avenue
Marshfield WI 54449

715-387-5004



**Marshfield Clinic
Health System**

Flexible Spending Accounts

Benefits

Marshfield Clinic Health System offers three types of flexible spending accounts (FSAs). The plan year for the FSAs is April 1 through March 31. Employees have 60 days from the end of the plan year or coverage end date to submit eligible expenses for reimbursement.

Diversified Benefit Services (DBS) administers all three plans. The contact information for DBS is **262-367-3300** or online at **www.dbsbenefits.com**.

The DBS website has extensive information regarding flexible spending accounts. Just click on participant resources for frequently asked questions, forms and information regarding how to file a claim.

Medical Expense FSA:

- A Medical Expense Flexible Spending Account (MEFSA) is available to benefit-eligible employees at the Health System who are not enrolled in the HDHP health insurance plan and do not contribute to a HSA.
- Contributions are made on a pre-tax basis with a minimum contribution of \$100 and a maximum of \$2,750.
- Participants are able to carry over up to \$500 only to the next plan year.

Limited Purpose FSA:

- A Limited Purpose Flexible Spending Account (LPFSA) allows a participant to remain HSA eligible and take advantage of a FSA for limited health care expenses.
- Contributions are made on a pre-tax basis with a minimum contribution of \$100 and a maximum of \$2,750.
- Participants are able to carry over up to \$500 only to the next plan year.

Dependent Care FSA:

- A Dependent Care FSA enables working parents to pay for child care using pretax earnings.
- Contributions are made on a pre-tax basis with a minimum contribution of \$100 and a maximum of \$5,000.
- The \$500 carry over does not apply to the Dependent Care FSA.

The IRS has guidelines regarding eligible expenses that can be reimbursed through a FSA. Here is a link to IRS Publication 969 outlining that information: **<https://www.irs.gov/forms-pubs/about-publication-969>**.

Section 125 Dependent Care participants are responsible for completing and attaching form 2441 to their 1040 tax form. Rulings and publications issued by the IRS can be found at **www.irs.gov**.

Please note that this is only a brief summary of these benefit plans and that the Plan Document overrules all other documents at all times. A complete copy of the plan document can be found on the Benefits Library/Flex Spending Accounts.



**Marshfield Clinic
Health System**

Health Savings Account

Benefits

Health Savings Account

A Health Savings Account (HSA) is available to benefit-eligible employees at Marshfield Clinic Health System who are enrolled in the HDHP health insurance plan. Contributions to an HSA are made on a pre-tax basis through payroll deduction. The IRS has guidelines regarding who can enroll in an HSA and how much can be contributed each year. Here is a link to IRS Publication 969 outlining those limits:

<https://www.irs.gov/forms-pubs/about-publication-969>

Fidelity is the administrator for the HSA, and they do charge a \$36 annual fee that is deducted from the participant's HSA account quarterly in \$9 increments.

Enrollment Process:

- After your benefit elections have been approved in Workday verifying that you have enrolled in the HDHP health insurance plan, Fidelity is notified of your eligibility to participate in a HSA.
- Go to the Fidelity website to open a health savings account: **www.netbenefits.com** or call Fidelity at **800-343-0860**.
- Fidelity will provide you with a health savings account number. After obtaining that account number, call Human Resources at **ext. 7-5254**, to set up your HSA contributions including your bi-weekly contribution.
- After completing these steps, HSA contributions should appear on your pay slips and in your Fidelity account.

Please note that this is only a brief summary of this benefit plan and that the Plan Document overrules all other documents at all times. A complete copy of the plan document can be found on the Benefits Library/Health Savings Account.



**Marshfield Clinic
Health System**

2020 Salary Reduction Plan 401(k) Details

Benefits – Staff

Eligibility Criteria

- Must work 1,000+ hours a year, and
- Be age 21 or older

Automatic Enrollment

Marshfield Clinic Health System's Salary Reduction Plan 401(k) utilizes an automatic enrollment feature. Unless you opt-out of auto enrollment, **you will be automatically enrolled** in our 401(k) plan at a 6% contribution rate approximately 60 days after you begin employment. A 6% contribution rate ensures you will receive the full employer matching contribution provided by Marshfield Clinic Health System. You may opt-out of auto-enrollment prior to the expiration of the 60-day period by contacting Fidelity Investments at 1-800-343-0860. You may also enroll directly using the options listed in the "Options to Directly Enroll" area of this instruction handout. Enrolling directly removes you from the automatic enrollment process.

Options to Directly Enroll

- Enroll online: www.netbenefits.com
- Speak to a **Fidelity Retirement Services Specialist** at 1-800-343-0860 and enroll

Matching Contributions

Marshfield Clinic Health System will help your savings grow by matching your 401(k) contributions. Marshfield Clinic Health System will match up to 50 cents for each dollar you contribute to your 401(k) account on the first 6% of your salary.

Two Ways to Contribute

- **Traditional (Pre-Tax) 401(k)**
 - Contributions are taken from your pay before income taxes are taken out
 - You can lower the amount of current income taxes you pay each pay period
- **Roth (Post Tax) 401(k)**
 - Contributions are taken from your pay after income taxes are taken out
 - Monies will be tax exempt when you withdraw the monies in retirement, provided several other Roth requirements are met

Annual Contributions

You may elect up to 100% of your compensation for 401(k) contributions, not to exceed the maximum contribution limit of **\$19,500 in 2020**. If you are age 50 or older during the calendar year you may make an additional **"catch up" contribution of \$6,500 in 2020, for a total of \$26,000**.

Investment Options

You have the flexibility to select from investment options that range from more conservative to more aggressive, making it easy for you to develop a well-diversified investment portfolio.

This notice is being provided in order to comply with various governmental disclosure requirements regarding your access to the important documents that govern the operation of the Salary Reduction Plan of Marshfield Clinic Health System (the 401(k) plan) and Marshfield Clinic Health System Retirement Plan.



**Marshfield Clinic
Health System**

2020 Retirement Plan Contributions

Benefits – Staff

Marshfield Clinic Health System's retirement benefits include the Employee's Retirement and 401(k) Plans. As with Section 125 benefits discussed above, the IRS has limitations on maximum retirement plan contributions and the rules are as follows:

Rule #1

Your 401(k) contribution may not exceed \$19,500 in 2020.**

"Catch Ups" for employees age 50 and older will include an additional \$6,500 for 2020. The limit is indexed for inflation thereafter.

Rule #2

Retirement Plan contributions cannot exceed \$57,000* annually. These contributions include the Clinic's retirement and 401(k) contributions, and your own 401(k) contributions.

*Plus Catch Up if eligible.

Rule #3

Retirement Plan contributions cannot exceed 100% of salary. Contributions include your own 401(k) contribution, the Clinic's matching 401(k) contribution and Retirement Plan contribution.

- Participants may elect up to 100% of their compensation for 401(k) contributions. The actual amount deducted will first be adjusted to offset for compliance of Rules #1, #2, and #3, FICA tax, health, dental and any other scheduled payroll deductions.
- **Compensation Limit:** The amount of an employee's compensation that can be considered for 401(k) and the Retirement Plan contribution is \$285,000 for 2020.
- 2020 Social Security Wage Base: \$137,700

Employee's Retirement Plan of Marshfield Clinic Health System (ERP)

Marshfield Clinic Health System fully funds a retirement plan for the benefit of all eligible Marshfield Clinic Health System Staff. Contributions are made annually based on meeting the following criteria: age 21 prior to or as of the last day of the calendar year, worked a minimum of 1000 hours during the calendar year (based on the paychecks received in the calendar year) and actively employed as of the last business day of the calendar year.

An eligible participant will receive a contribution equal to 3% of the participant's compensation, plus an additional contribution equal to 3% of the participant's compensation in excess of the Social Security Wage base. The amount of compensation considered for retirement plan contributions is limited. Marshfield Clinic Health System's compensation limit is reviewed periodically and adjusted at the discretion of the Board of Directors.

All participants are 100% vested in their accounts. Each participant selects how his or her account will be invested. Statements are sent to each plan participant. Contributions are deposited six weeks following the end of the year.



Marshfield Clinic
Health System

Paid Time Off Benefits

Paid time off (PTO) is a benefit provided by Marshfield Clinic Health System to eligible employees. The details surrounding PTO are governed by the Paid Time Off Policy.

Some important aspects summarized from the Paid Time Off Policy include:

- Only unused earned PTO as defined in the policy will be paid out upon applicable transfer or termination of employment. Employment cannot be extended with the use of PTO.
- Hourly employees earn PTO hours each pay period based on counted hours during the pay period. Earned hours are awarded on a per-pay-period basis and can be used in as little as quarter hour increments as soon as reflected in your Workday balance.
- Salaried employees who are advanced PTO hours at the beginning of the calendar year or at the time of hire or transfer use PTO in 4- or

8-hour increments. PTO is not earned until the employee has actually worked the required number of days in the calendar year. Employees who are salaried and end employment or eligibility for the benefit, will be required to reimburse overused hours, and Marshfield Clinic Health System may deduct the reimbursement from the employee's pay check(s).

- All PTO requests, planned or unplanned, must be approved by the employee's manager.
- Employees are responsible for keeping sufficient hours in their PTO account for unexpected time off.

Paid Holidays are treated as a separate benefit.

Salaried (paid biweekly) Benefit Status

Group	Completed years of service	Annual hours (Prorated for less than 1.0 FTE status and partial years)
Group II	< 10	168
	10 - 24	208
	25+	248
Group IA	< 5	168
	5 - 24	208
	25+	248
Group Administration & Executive Administration	< 3	168
	3 - 15	208
	16 - 24	248
	25+	288

Hourly Groups

Group	Completed years of service	Paid time off accrual rate per counted hour	Annual maximum accrual hours* (based on 2080 paid hours)	Maximum balance allowed*
Group III Hourly	0 - 1	.0385	80	120
	1 - 4	.0615	128	168
	5 - 14	.0808	168	208
	15 - 24	.1000	208	248
	25+	.1192	248	288
Group IIH Hourly	< 10	.0808	168	208
	10 - 24	.1000	208	248
	25+	.1192	248	288
Baylor	7/70 schedule (all years of service)	.0202	42	82
	Weekender < 10 years 24/32/36 schedules	.0385	72	102
	Weekender 10+ years 24/32/36 schedules	.0481	90	130

* Paid time off will commence accruing again either 1) at the beginning of the pay period of a new anniversary/hire period if paid time off accrual stopped as a result of reaching 2080 paid hours or 2) once an employee has used paid time off hours and their balance falls below the maximum balance allowed.



**Marshfield Clinic
Health System**