Oregon Episcopal School

2022 EMPLOYEE BENEFITS GUIDE

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2022 OPEN ENROLLMENT

WELCOME TO OPEN ENROLLMENT

Oregon Episcopal School is pleased to offer a comprehensive program of group benefits to help maintain the health and well-being of you and your eligible family members. Our benefit plan objectives are to provide you with benefits for maintaining good health and financial protection in the event of a disability or death. The ability to continue these benefit programs is a partnership between Oregon Episcopal School and our employees. With the double-digit rate of healthcare inflation, we must use our benefits wisely.

This guide is a brief overview of your benefit plans, the enrollment process and timelines. More detailed descriptions of benefits eligibility, waiting periods, and benefits are contained in your Summary Plan Descriptions (SPDs), which are your benefit booklets and group certificates. You'll find these on our benefits website and in the HR Office.

IMPORTANT DATES:

All Employee Meeting:
October 19th
3:30 pm

QUESTIONS?

Contact:
Veena Iyengar
(503) 416-9482
iyengarve@oes.edu

PLAN HIGHLIGHTS / WHAT'S NEW

- **Enriched Chiropractic and Acupuncture Benefits:** The combined calendar year maximums have been removed for these services. Beginning in 2022, the plans will offer 20 visits for chiropractic manipulations *and* 12 visits for acupuncture services. In addition, member cost share (copays) will apply to the Out-of-Pocket maximums. (Note that massage therapy will continue to be covered as usual under the alternative care option, subject to the $1,500 calendar year max.)

- **Alight Personal Health Pro Services:** Did you know that there is a service available to you to help you with all your health care needs? While this is not a new program for 2022, it is definitely one OES would like to showcase. Through our contract with Alight, you have access to a Health Pro consultant who is waiting to help you and your family members navigate health care. You may contact Alight to help find providers, compare prices for healthcare services, resolve billing questions, or just get a deeper understanding of your benefits in general. In addition, Alight will help you schedule your appointments for health care services. See page 9 in this guide for how to contact our Health Pro consultant at Alight.

- **OES Group Medicare Plan With Providence:** If you are of Medicare age and not working a full-time schedule at OES, you may consider enrolling in this new plan, and OES will pay 100% of the cost for you and your eligible spouse. If you are not yet eligible for Medicare but your spouse is, you have the option to select the Medicare plan for your spouse at no premium contribution. The plan available is a Providence Advantage plan, meaning that medical and pharmacy benefits are provided all in one plan. In addition, the Explore HMO+ Prescription Drug plan offers a Dental Buy Up option.

EMPLOYEE BENEFITS

BENEFITS	FUNDING	COVERAGE OPTIONS
Medical benefits underwritten by Providence Health Plans	Employee and Employer Paid	• Benefits are available for office visits, inpatient surgery, outpatient surgery, prenatal care, preventative care, urgent and emergency care.
Prescription benefits underwritten by Providence Health Plans	Employee and Employer Paid	• Coverage for generic & brand name prescription drugs. No annual deductible.
Health Pro consultant services administered by Alight-Personal Health Pro Services	Employer Paid	• Available to help you and your family members navigate health care. Assistance available to help find providers, compare prices, resolve billing questions and to understand your benefits.
Dental Benefits administered by Kaiser, Willamette Dental and Delta Dental	Employee and Employer Paid	• Benefits are available for minor and major dental services including routine exams and teeth cleaning.
Vision benefits underwritten by Vision Service Plan (VSP)	Employee and Employer Paid	• Provides benefits for eye exams, lenses, frames and/or contacts.
403(b) administered by AIG	Employee and Employer Contributions	• The School contributes 7.5% when you contribute at least 5% of your gross monthly income to the plan and 4% when you contribute at least 2.5%.
Flexible spending accounts administered by HealthEquity	Employee Contributions	• Can reduce taxable income and cover medical, dental and vision expenses as well as dependent day care.
Group Term Life and AD&D insurance underwritten by Sun Life	Employer Paid	• OES automatically insures one times your annual base salary for life and AD&D insurance, rounded up to the nearest $1,000. This benefit is 100% employer-paid up to a maximum of $200,000.
Group Voluntary Term Life AD&D insurance underwritten by Sun Life	Employee Paid	• Available to eligible employees in increments of $10,000 up to the lesser of $500,000, or five times your basic earnings. Spouses or domestic partners may elect up to 100% of employee amount in $5,000 increments. Child coverage is available in $2,000 increments to $10,000 maximum.
Group Long Term Disability insurance underwritten by Sun Life	Employee Paid	• Benefit can pay 60% of pre-disability earnings to a maximum of $3,000 per month;benefits can be paid up to Social Security Normal Retirement Age, after 90 days of disability.
Global Travel Services administered by Assist America	Employer Paid	• Provides services when you are at least 100 miles from home such as prescription assistance, emergency medical evacuation and lost luggage.
Voluntary Long Term Care underwritten by Transamerica (grandfathered plan)	Employee Paid	• Long-term care insurance policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating.

ENROLLMENT AND ELIGIBILITY

ELIGIBILITY

Calendar (July - June) or academic year (September - June) employees that work at least 1000 hours per year and faculty working at least half-time are eligible for the health insurance plans. Coverage begins on the first day of the month following the date of hire. If hired on the first of the month, the insurance benefits will be effective that day. You may elect medical, vision, and/or dental coverage for yourself and dependents including your legal spouse, domestic partner or dependent children under the age of 26.

ANNUAL OPEN ENROLLMENT

1. Open Enrollment occurs annually. Open enrollment allows you to enroll or make changes such as add or delete dependents to your current benefits. Those changes or additions are effective January 1.
2. All employees will need to complete the Open Enrollment process through GNSA, by **Monday, November 15, 2021**, even if you are waiving coverage. After you complete the GNSA process, you may be asked to complete additional information based on your enrollment decisions.
3. To participate in the Health Equity Flexible Spending Account (FSA) and Health Savings Account (HSA) in 2022, you must complete your enrollment through the GNSA portal by **Monday, November 15, 2021**.

GENERAL ENROLLMENT INFORMATION

- When a life-changing event occurs (marriage, divorce, birth, etc.), you can make a mid-year change to your current benefit elections without waiting for the annual open enrollment period.
- Enrollment changes can only be made within 31 days of the qualifying event and must be consistent with the change in status. After the 31-day time frame, you are only able to change your elections during the annual open enrollment period.

WHEN COVERAGE ENDS

Your benefit plan participation and the participation of your eligible dependents will terminate on the last day of the month in which you terminate employment with Oregon Episcopal School. For Life, Disability, Voluntary Plans and FSA, benefits will end on the last day of employment. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the eligibility hours requirement, and/or if you submit false eligibility or claims information.

BENEFIT GLOSSARY

The following definitions should help you understand your benefit plans. Remember, you have access to In-Network and Out-of-Network providers. Our Medical, Dental and Vision network providers have contracted rates that can be much lower than Out-of-Network providers. Your out of pocket expense may be lower by using In-Network providers.

Calendar Year Deductible (CYD) - The amount you pay before co-insurance is paid. You only need to meet your deductible once per calendar year.

Co-Insurance - The percentage of cost-sharing between what you and the insurance company must pay, after any applicable deductible has been met.

Co-Pay - The set dollar amount that you must pay to a provider when services are rendered.

Explanation of Benefits (EOB) - The insurance company's written explanation regarding a claim, showing what they paid and what the patient must pay. The EOB is not a bill, although it will explain any charges that the patient still owes or may have already paid (in the form of a copay at the time the medical care was received, for example). If the patient owes additional money after the insurance company has paid its portion, the medical provider will send a separate bill, which should match the patient's portion listed on the EOB.

Health Reimbursement Arrangement (HRA) - A plan used to administer reimbursements on qualified medical expenses that apply towards the deductible. The reimbursements are funded by the employer.

Health Savings Account (HSA) - A tax-free savings account that is owned by the employee. It can be used to pay for insurance deductibles and qualified out-of-pocket medical expenses. Deposits into the HSA can be made by the employee and employer. If adult children (non-tax dependent) are enrolled on the HSA plan, they may need to set up their own HSA.

Out-of-Pocket-Maximum - The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Outpatient - A patient who receives treatment at a hospital or outpatient facility without being admitted overnight.

Preferred Provider Organization (PPO) - A network of providers that has agreed to contracted rates with the insurance carrier. A PPO plan pays claims from In-Network and Out-of-Network providers. Members may see reduced out of pocket costs when utilizing In-Network providers.

Provider - Any facility, person, or entity recognized for payment by the insurance company.

Usual, Customary and Reasonable (UCR) - The determined going rate for like services in the same area. The insurance companies co-insurance percentage that they pay is taken from the UCR amount for that service. You are responsible for your co-insurance percentage plus all of the amount that exceeds UCR. UCR is used only when services are provided by an Out-of-Network provider.

YOUR 2022 MONTHLY BENEFIT PLAN COSTS:

75% TO 100% FULL-TIME EMPLOYEES				
PLAN SELECTED	**EMPLOYEE**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + FAMILY**	**EMPLOYEE + CHILD(REN)**
Providence Option Advantage (Open Option)	$145.36	$875.13	$1,335.20	$738.48
Providence Personal Option (In-Network)	$23.59	$619.61	$995.38	$508.00
Providence HSA Plan	$109.28	$528.79	$818.47	$442.73
Kaiser Dental	$3.78	$60.52	$117.26	$49.17
Willamette Dental	$2.42	$36.92	$73.18	$38.72
Delta Dental	$2.97	$47.47	$101.08	$63.07
VSP Vision	$0.37	$3.72	$9.47	$3.90

50% TO 74% PART-TIME EMPLOYEES				
PLAN SELECTED	**EMPLOYEE**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + FAMILY**	**EMPLOYEE + CHILD(REN)**
Providence Option Advantage (Open Option)	$296.36	$1,423.47	$2,134.06	$1,212.42
Providence Personal Option (In-Network)	$174.59	$1,167.95	$1,794.24	$981.94
Providence HSA Plan	$220.28	$1,077.13	$1,617.33	$916.67
Kaiser Dental	$15.13	$90.78	$166.43	$75.64
Willamette Dental	$9.67	$55.67	$104.02	$58.07
Delta Dental	$11.87	$71.21	$142.68	$92.01
VSP Vision	$1.48	$5.94	$13.61	$6.18

MEDICARE ELIGIBLE EMPLOYEES WORKING LESS THAN FULL TIME*	
Explore HMO	OES is covering the cost of these plans in full.
Dental Buy Up	

* Note that this is a Medicare rule, not an OES rule.

MEDICAL AND PRESCRIPTION DRUG COVERAGE

For 2022, OES is offering the following medical, prescription drug, and alternative care plans through Providence. Please see page 7 for the 2022 employee contributions. The following is a brief summary of the medical plans. For more detailed information, please refer to your Providence Handbook.

BENEFITS	PROVIDENCE PERSONAL OPTION (IN-NETWORK)	BUY UP PLAN PROVIDENCE OPTION ADVANTAGE (OPEN OPTION)	PROVIDENCE HSA^
PROVIDER NETWORK	**PARTICIPATING PROVIDERS ONLY**	**IN NETWORK / OUT OF NETWORK**	**IN NETWORK / OUT OF NETWORK**
Lifetime Maximum	None	None	None
Calendar Year Deductible	$500 Individual* $1,000 Family*	$250 Individual $500 Family	$1,500 Individual $3,000 Family
Out of Pocket Maximum** (Deductible, Coinsurance and Prescription Drug out-of-pocket costs all accumulate towards the out-of-pocket maximum)	$2,000 Individual* $4,000 Family*	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family
OFFICE VISITS			
Primary Care/Specialist	Primary Care: $15 Specialist: $25	$15 / 40% (no ded)	20% / 40%
Phone and Video Visits with Primary Care Provider, or, Providence ExpressCare Retail Health Clinics	$0	$0 / Not covered	$0 / Not covered
Preventive Care	$0	$0 / 40% (no ded)	20% / 40%
Maternity Care: Pre-natal care Delivery and post-natal Inpatient hospital/facility Routine newborn nursery care	$0 $150 delivery (no ded) 30% 30% (no ded)	$0 / 40% $150 delivery (no ded) / 40% 20% / 40% 20% (no ded) / 40%	20% / 40%
Inpatient Hospital Visits	30%	20% / 40%	20% / 40%
Lab/X-Ray and Imaging	30% (no ded)	20% (no ded) / 40%	20% / 40%
Durable Medical Equipment	30%	20% / 40%	20% / 40%
Spinal Manipulation, Acupuncture	$15; Chiro: 20 visit annual max, Acu: 12 visit annual max,	$15 / $15; Chiro: 20 visit annual max, Acu: 12 visit annual max,	20% / 20%; Chiro: 20 visit annual max, Acu: 12 visit annual max,
HOSPITALIZATION			
Inpatient	30%	20% / 40%	20% / 40%
Outpatient Surgery	30%	20% / 40%	20% / 40%
Emergency Room	$250 (no ded)	$250 (no ded) / $250 (no ded)	20% / 20%
Urgent Care	$15	$15 / 40% (no ded)	20% / 40%
ALTERNATIVE CARE			
Massage Therapy	$15 copay, $1,500 annual max	$15 copay, $1,500 annual max	$25 (after ded) to $500 max
PRESCRIPTION DRUG CO-PAY^^			
Tier 1	$0	$0	20% ($0 Preventive) / Not covered
Tier 2	$10	$10	20% / Not covered
Tier 3 / Tier 4	$30	$30	20% / Not covered
Tier 5 / Tier 6	$30	$30	50% (not to exceed $200) / Not covered
Mail Order	2 copays for 90 day supply	2 copays for 90 day supply	20% / Not covered

* Deductible and out-of-pocket maximum after qualified credit of $1,000 per member through Health Reimbursement Arrangement.

** Premiums, penalties, copays or coinsurance for supplemental benefits, services not covered and fees above UCR *are not* included in the Out of Pocket Maximum. Even though you pay these expenses, they don't count toward the out-of-pocket limit.

^ Please note, with the exception of preventive care, all services under the HSA plan are subject to deductible.

^^ To find out how a drug is covered under your plan, log into your Providence account to view the complete formulary and pharmacy information available online at https://www.providencehealthplan.com or call (503) 574-6595.

alight

Take advantage of your benefit!

Healthcare costs are rising, benefits can be confusing and finding the right care can be frustrating and time-consuming. Don't worry! Help has arrived. You now have a personal Health Pro® consultant ready to assist you and your family.

- **Understand your benefits**
  Clear up any confusion about your health plan.
- **Find great doctors**
  Locate highly-rated doctors, dentists and eye care professionals.
- **Save money on healthcare**
  Compare prices and choose more cost-effective options.
- **Pay less for prescriptions**
  Get recommendations for lower-cost medications.
- **Resolve billing errors**
  Over 30% of medical bills are wrong. Don't overpay.
- **Schedule appointments**
  Have your appointments scheduled at times most convenient for you.

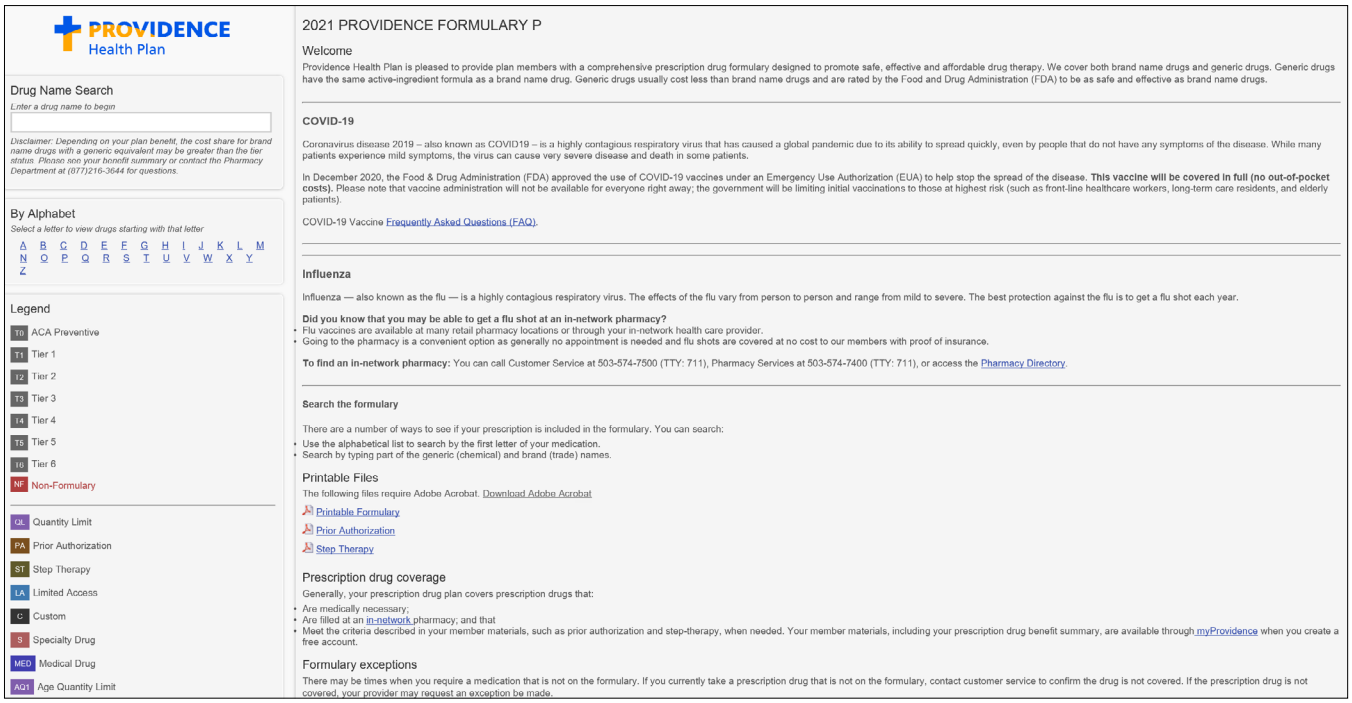
Get started:Nicole.Heinrich@alight.com | 800-513-1667 X 2854

FORMULARY P - YOUR ONLINE RESOURCE

Providence provides access for members to find out how a drug is covered under their plan with an online resource tool called Formulary P. The site has the following capabilities:

- Interactive formulary
- Search by medication name
- Find out if your prescription requires prior authorization or any other special considerations
- Search for alternative medications

The prescription drug formulary is accessible through the secure member portal. Visit myProvidence.com to sign up for your account.



PROVIDENCE CUSTOMER SERVICE PHONE NUMBERS

Providence Resource Line	(503) 574-6595
Providence Hospitals & Clinics	(503) 215-4300
Providence Health Plan	(503) 574-7500
myProvidence	(503) 216-6463
MyChart	(833) 395-2035

First things first...

Sign up for a myProvidence account

Register today to securely manage and access your health plan however and whenever you like.

- **Find in-network providers**
- **Get a replacement ID card**
- **Estimate costs for medical, pharmacy, and dental**
- **View claims, details and explanations of benefits**
- **View progress towards your deductible and out-of-pocket maximum**
- **Learn more about your benefits**
- **Take a personal health assessment**
- **Communicate with Customer Service via secure email and chat**
- **Go paperless with your Explanation of Benefits (EOBs)**

myProvidence.com

myProvidence help desk 503-216-6463
8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

Get the most from your plan

Our Providence customer service team will help you make the most of your plan — even before membership begins just call **503-574-7500**. Some of the things we can do are:

- **Help you find a medical home of your choice**
- **Guide you to the right providers and specialists**
- **Transfer prescription medication**
- **Seamlessly transition existing care**

Convenient access to medication

Our preferred pharmacy network gives you access to more than 36,000 participating pharmacies, including retail, preferred retail, mail order and specialty. You can conveniently access the medications you need and save yourself both time and money when obtaining your prescription drugs.

Preferred retail pharmacies

With a preferred pharmacy, you usually pay less when you fill a 30- to 90-day supply of medications. Nearly all in-network pharmacies are preferred — including most major drug store chains.

Mail order pharmacies

With many plans, using mail order allows you to purchase a 90-day supply of medications at a reduced cost and have them delivered to your home.

Specialty pharmacies

When it comes to ordering specialty medications, you can count on a specialty care coordination team that's available to assist. Your care team will help coordinate benefit plans, costs and access to medications, so that individuals can achieve their health goals at the lowest net cost possible.

For preferred pharmacy listings and mail order set-up, log in to your myProvidence account.

Get the right care at the right time at the right place

ProvRN Free

Access to care 24/7

Speak with a registered nurse anytime, any day. An easy first step when you have symptoms and you want to know if you need face-to-face care.

- Always free, always there for you
- Connect with a nurse at 800-700-0481 or 503-574-6520

ExpressCare Virtual Free*

Getting the care you need, when you need it

Talk with a provider from anywhere using your tablet, smartphone or computer. This is a great option for prescriptions and treatment that don't require hands-on care. Available nationwide.

- 8 a.m. – 8 p.m., (Pacific TIme) daily

ExpressCare Clinics Free*

Same-day, in-person treatment

When you need to see someone and your regular care provider isn't available.

- 7 days a week

Primary Care $

Your primary healthcare partner

Primary care providers develop a relationship with you and know your health history. Visit them for check-ups, managing chronic conditions and specialist referrals.

- By appointment
- Call your primary care provider

Urgent Care $$

When you need help right away

Urgent care is where you turn when you know you need help and can't wait for an appointment. This is best for minor injuries, cuts, burns, pains and sprains.

- Hours vary by location

Emergency $$$$

When you think you may be in danger

Use emergency care for suspected heart attack, stroke, severe abdominal pain, poisoning, choking, loss of consciousness and uncontrolled bleeding.

- Available 24/7
- Get a ride to the nearest hospital

If you ever think your life or well-being could be in serious danger, call 911 immediately.

*ExpressCare Virtual and ExpressCare Clinic services are free with most plans.
HSA plan members must first meet their plan deductible; then services are covered in full.

More ways to reach True Health

Active&Fit Direct®

Ready to kick-start a routine or looking to take it to the next level? Access more than 11,000 participating fitness centers, 2,500 digital workout videos or daily weekday workout classes on Facebook Live and YouTube for just $25 per month (plus a $25 enrollment fee and applicable taxes; 2-month commitment required).

Personal Health Coach

Thinking about a healthier lifestyle but don't know where to start? Providence personal health coaches are here to support your journey to a healthier, happier life.

LifeBalance

Get discounts on the things you love to do from movies to travel to a night on the town. LifeBalance provides savings on more than 20,000 travel, cultural, recreational and other fun activities.

ChooseHealthy

We want to give you every opportunity to achieve your health goals. Save big on fitness and wellness products, services and memberships.

Behavioral Health Network

Connect with a direct access line to a dedicated behavioral health and substance abuse service support team, which includes a crisis-trained staff. This team is available 24/7, seven days a week for members. Just call 800-878-4445 for assistance.

Emergency Travel Assistance

Get emergency medical help while traveling away from home, or even internationally, with Assist America Travel Assistance.

ID Protection

Get peace of mind with Assist America Identity Theft Protection's fraud monitoring, warning and resolution.

For information on these programs, visit

myProvidence.com

Prices, terms and offerings subject to change.

Behavioral health support is only a call or click away

NEW! Providence Behavioral Health Concierge

Providence Health Plan members and dependents in Oregon, Washington, Idaho, Montana, California, and Texas can access virtual and confidential same-day or next-day appointments at no cost, with Providence licensed behavioral health professionals. This evidence-based and solution-focused service is a convenient way to seek help from a mental health provider.

The Behavioral Health Concierge offers:

- Help with life stressors, mental health and addiction issues
- Support for you and your family
- HSA plans are subject to deductible first and then covered in full (for more information, call customer service*)
- Counseling, care guidance and self-help tools
- All appointments are virtual
- Translation services available upon request

Schedule an appointment today

Call 877-744-WELL (877-744-9355) from 7 a.m. to 8 p.m. (Pacific Time), seven days a week or visit ProvidenceHealthPlan.com/BehavioralHealth for more information about scheduling.

*Customer service is available 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday. Call 503-574-7500 or 800-878-4445 (TTY: 711).

Behavioral Health Concierge is owned and operated by Providence St. Joseph Health (PSJH)

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) - HEALTH EQUITY

FOR OES EMPLOYEES ENROLLED ON THE PROVIDENCE PERSONAL OPTION IN-NETWORK PLAN

OES has a HRA in place to offset the deductible costs on our Providence Personal Option medical plan.

Here's how it works:

- Each employee enrolled on the Personal Option plan has an arrangement through the HRA that will reimburse up to $1,000 for each employee and up to $2,000 maximum per family.
- You are responsible for the first $500 of deductible expenses on the Personal Option plan per enrolled individual:
  - Any deductible expenses from $501 - $1,500 will be paid directly to your provider by Health Equity.

Eligible expenses include deductible expenses associated with the Personal Option medical plan. Copays and coinsurance are NOT eligible expenses.

- Funds run according to the plan year (January 1st – December 31st).
- Unused HRA dollars do not roll over from year to year.

HEALTH SAVINGS ACCOUNT (HSA) - HEALTH EQUITY

FOR OES EMPLOYEES ENROLLED ON THE PROVIDENCE HSA PLAN

Eligible employees who elect the HSA medical coverage will have a HSA automatically set up through Health Equity. A HSA can be used to pay for health care costs not covered by the Providence HSA qualified health plan. **OES will make a monthly contribution of $170 on behalf of all employees enrolled in this plan.** If you currently have a HSA elsewhere, you can rollover your current HSA balance to Health Equity, if you wish. To do this please complete an HSA Rollover form and send to your previous bank as soon as possible.

To be eligible to open and contribute to a HSA you must be:

1. Enrolled in the Providence HSA qualified plan.
2. Not covered by any other health plan or insurance except those identified by the IRS. (Possibly including military, tribal, medivac - Please check with your tax advisor if you have any questions.)
3. Not enrolled in Medicare.
4. Not claimed as a dependent on another individual's tax return.
5. Not enrolled in a "Full" Health Flexible Spending Account (FSA). This includes a spouse's traditional Flex Plan.
6. You have not received Veterans Administration (VA) benefits within the past three months.

In addition to OES' contribution to your HSA, employees may make pre-tax payroll contributions up to the IRS maximums. The funds accumulated in your HSA are owned by you and are portable should you cease to be employed by OES. If you have single HSA coverage and are under the age of 55, you may (but are not required to) contribute up to **$1,610** into your HSA for 2022. If you have family HSA coverage and are under the age of 55, you may (but are not required to) contribute up to **$5,260** into your HSA for 2022. Please note total contributions (employee plus employer) cannot exceed **$3,650** for employees under age 55 with single HSA or **$7,300** for employees under age 55 with family HSA coverage for 2022 (not counting rollover amounts). An additional catch up contribution of **$1,000** applies if you are over 55 years of age.

DENTAL BENEFITS

OES offers dental plans through Kaiser, Willamette Dental and Delta Dental of Oregon. The Delta Dental plan offers a choice of in- and out-of-network providers. Kaiser and Willamette Dental require that you use providers from their network in order for benefits to be covered. Please see page 7 for the 2022 employee contributions. The following is a brief summary of the dental plans. For more detailed information, please refer to your Benefit Summary.

BENEFITS	KAISER	WILLAMETTE DENTAL	DELTA DENTAL
PROVIDER NETWORK	**KAISER ONLY**	**WILLAMETTE DENTAL ONLY**	**ALL DENTISTS, EXCEPT FOR KAISER**
Annual Deductible	$50 per person $150 per family	None	$50 per person $150 per family
Annual Maximum	None	None	$1,000 per person
SERVICES			
Office Visit Copay	$10	$15	None
DIAGNOSTIC/PREVENTIVE SERVICES			
Exams, cleanings, x-ray	100% deductible waived	100%	100% deductible waived*
BASIC/RESTORATIVE SERVICES			
Fillings and simple extractions	100% after deductible	Copay varies, based on service	80% after deductible**
MAJOR SERVICES			
Oral Surgery, crowns, and dentures	80% after deductible	Copay varies, based on service	50% after deductible**
ORTHODONTIA COVERAGE			
(Lifetime Maximum) No waiting period	50% to $3,000 for subscribers under 18 years of age. Member copay required	$2,700 Member Copay Required	Not covered

*Preventive services will not accumulate towards your annual maximum of $1,000.
**UCR is set at 90th Percentile.

VSP VISION PROGRAM

OES offers vision coverage through Vision Service Plan (VSP). This plan offers coverage for both in-network and out-of-network providers. You are automatically enrolled in VSP when you elect medical coverage; however you may elect vision coverage only. Please see page 7 for the 2022 employee contributions. The following is a brief summary of the vision plan. For more detailed information, please refer to your VSP Benefits Summary.

Please note, no ID card is required; your name and social security number are the identification used to access benefits.

COVERAGE	VSP PROVIDERS	NON-VSP PROVIDERS
EXAM		
Once every 12 months	$10 copay, then covered in full	Reimbursed up to $43
FRAMES		
Every 24 months	Covered up to $140 allowance; Covered up to $160 allowance for featured frame brands	Reimbursed up to $70
LENSES (STANDARD UNCOATED PLASTIC)		
Single Vision (every 12 months)	$25 copay, then covered in full	Reimbursed up to $30
Lined Bifocal (every 12 months)	$25 copay, then covered in full	Reimbursed up to $50
Lined Trifocal (every 12 months)	$25 copay, then covered in full	Reimbursed up to $65
CONTACT LENSES		
In lieu of frames and lenses, every 12 months	Up to $60 copay for fitting and evaluation, then covered up to $140 allowance	Reimbursed up to $105
ALL OTHER MATERIALS		
Non-Rx Sunglasses, Accessories, Etc.	Discounts available	

LIFE AND DISABILITY

GROUP LIFE INSURANCE AND AD&D GROUP LIFE INSURANCE AND AD&D - SUN LIFE

Group Term Life Benefits: This plan pays your beneficiary a specified benefit in the event of your death. Employees are covered at 1 x your annual earnings, to a maximum of $200,000. OES pays 100% of the cost of this benefit.

AD&D Benefits: This plan pays a benefit to your specified beneficiary in the event of your death from an accidental injury or a benefit to you in the event of your dismemberment from an accidental injury. You are covered at 1 x your annual earnings to a maximum of $200,000. OES pays 100% of the cost for this benefit.

SUPPLEMENTAL (VOLUNTARY) LIFE INSURANCE AND AD&D - SUN LIFE

Voluntary Life Insurance: This plan allows you to elect coverage for yourself and your dependent family members. You may elect up to 5 x your annual earnings to a maximum of $500,000 in $10,000 increments. If you enroll during your initial eligibility period, no medical questions will be asked until your coverage exceeds $110,000. If you enroll after your initial eligibility period, you will need to complete an application and medical questionnaire and receive approval from Sun Life for coverage requested. Likewise, your spouse or domestic partner may elect up to 100% of your amount, in $5,000 increments. No medical questions are asked until coverage exceeds $25,000 if enrolling during the employee's initial eligibility period. Dependent children are also eligible for up to $10,000 of coverage in $2,000 increments.

Voluntary AD&D: This plan allows you to elect coverage for yourself and your dependent family members. AD&D is completely stand alone to the Optional Life. The employees can elect VAD&D even if they have not elected Optional Life, or can elect a different amount of VAD&D than their Optional Life election. You may elect up to 5 x your annual earnings to a maximum of $500,000 in $10,000 increments. Likewise, your spouse or domestic partner may elect up to 100% of your amount, in $5,000 increments. Dependent children are also eligible for up to $10,000 of coverage in $2,000 increments.

LONG TERM DISABILITY - SUN LIFE

If you are disabled by an injury or illness, our LTD plan provides income benefits as long as you are physician-certified as disabled, or until retirement age, whichever is earlier. A monthly benefit of 60% of monthly salary to a maximum of $3,000 is payable after a 90-day waiting period. All employees are required to pay for their own disability coverage, but the benefits will be tax-free. Employee Paid Premium is 0.265% of monthly earnings to a maximum coverage of $3,000 monthly. Example: Salary is $3,000/month = LTD premium of $7.95/month

VOLUNTARY LONG TERM CARE (LTC) - TRANSAMERICA

Voluntary LTC: Unlike traditional health insurance, long-term care insurance is designed to cover long-term services and support, including personal and custodial care in a variety of settings such as your home, a community organization, or other facility. Long-term care insurance policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating. You can select a range of care options and benefits that allow you to get the services you need, where you need them. *For more information on this benefit, please contact HR as this is a closed plan.*

ASSIST AMERICA - GLOBAL TRAVEL SERVICES

OES provides you and your dependents with Assist America's Global Travel Services. Additional information is available at www.assistamerica.com. Coverage is in effect during all personal, vacation and business travel, domestic and international, as long as you are at least 100 miles from home. Unlike most travel policies, there are no dollar limitations in place for most of the following services:

- Medical Consultation, Evaluation & Referral
- Hospital Admission Guarantee
- Emergency Medical Evacuation
- Critical Care Monitoring
- Medically Supervised Repatriation
- Prescription Assistance
- Emergency Message Transmission
- Transportation to Join a Patient
- Care for Minor Children
- Return of Mortal Remains
- Lost Luggage or Document Assistance
- Interpreter & Legal Referral
- Pre-Trip Information

FLEXIBLE SPENDING ACCOUNT (FSA) - HEALTH EQUITY

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can actually lower your taxable income.

The Internal Revenue Service allows FSAs as a means to provide a tax break to employees and their dependents. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes - effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you realize, your spendable income will increase.

How do FSAs Work?

Your premiums will automatically be deducted pre-tax unless you elect otherwise. If you decide to enroll in the Health Care FSA or Dependent Care FSA, your contributions are taken out of each paycheck - before taxes - in equal installments throughout the plan year. These dollars are placed into your FSA into separate accounts (Health Care/Dependent Care). When you have an eligible health care expense, you can use your FSA debit card to pay for these expenses. In many cases, this automatic service may eliminate the need to file claims for reimbursement.

The Health Care FSA reimburses you for the full amount of your annual election (less any reimbursement already received), at any time during the plan year, regardless of the amount actually in your account. The Dependent Care FSA only reimburses you for the amount that is in your account at the time you make a claim.

Is an FSA Right for Me?

FSAs are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing or dependent care expenses beyond what his or her insurance plan covers. At enrollment time, you will need to determine your plan year contribution amount. Estimate the expenses that you know you will incur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you have $100 or more in recurring or predictable expenses, an FSA can help you stretch your dollars.

Please keep in mind, that once you have enrolled in the plan, you cannot change the amount elected. If you experience a life event change during the plan year such as marriage, divorce, birth or adoption of a child, or a spouse/domestic partner losing or gaining other coverage, you could qualify to make changes to your benefit plans. You are required to notify HR within 31 days of the date of the event to make benefit plan changes. Failure to notify HR within 31 days may disqualify you and require you to wait until the next open enrollment to make plan changes.

LIMITED HEALTH CARE FSA - FOR EMPLOYEES PARTICIPATING IN THE OES HSA MEDICAL PLAN

Employees enrolled in the Providence HSA medical plan and participating in the Health Savings Account are only eligible to participate in the Limited Health Care Reimbursement Plan. Employees can elect to contribute pretax amounts to pay for unreimbursed *Dental and Vision expenses* up to the maximum annual amount of $2,850.

FULL HEALTH CARE FSA - FOR EMPLOYEES NOT ENROLLED IN THE OES HSA MEDICAL PLAN OR ANY OTHER HSA QUALIFIED PLAN

This account enables you to use pre-tax dollars to pay for certain IRS-approved unreimbursed health related expenses. An example of these health related expenses are deductibles, copays and coinsurance. The maximum contribution to this account is $2,850 annually.

It is important that you carefully and conservatively determine how much to annually contribute to your FSA because:

- You must incur expenses during the plan year. The plan year for this benefit is January 1, 2022 - December 31, 2022.
- You cannot change your annual contribution amount during the plan year except for certain changes in your family status.

Carryover Provision for Limited and Full Health Care FSA

The plan year for the Health Care FSA is January 1, 2022 - December 31, 2022. If you do have remaining funds in your FSA account on December 31st, OES has a $570 carry over provision for our Section 125 plan. If you have any unused dollars at the end of the plan year (December 31, 2022), you will be able to carry over up to $570 to be used between January 1, 2023 - December 31, 2023.

DEPENDENT CARE FSA

This account enables you to use pre-tax dollars toward qualified dependent care. The annual maximum amount you may contribute to the Dependent Care FSA per plan year is $5,000 or $2,500 if married but filing taxes separately.

Eligible Expenses

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of a child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

For these services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse can go to work. Care must be given during normal working hours - Saturday night babysitting does not qualify - and cannot be provided by another of your dependents.

The same rules regarding changes in enrollment for the Healthcare Spending Account apply to this plan.

Flexible Spending Debit Card: If you enroll in either the Healthcare FSA or Dependent Care FSA, you and your spouse are eligible for a flexible spending debit card. The debit card can be used to pay for out-of-pocket costs for eligible medical, dental, and vision expenses for you and your qualifying dependents. Although using the debit card can limit the number of receipts that you may need to submit to Health Equity, Health Equity may still require submission of receipts on certain claims. It is always good to keep your receipts in a safe place.

You must re-enroll each year in the dependent care and healthcare spending accounts. Your share of dependent medical and dental premiums will be automatically deducted pre-tax, unless you elect otherwise.

EMPLOYEE ASSISTANCE PROGRAM (EAP) 1-800-433-2320

OES makes available to you and your family the confidential services of Cascade Centers EAP. Trained counselors will work with you or your family members on personal relationships, workplace issues, substance abuse, emotional/mental health issues, wellness concerns and other problems. OES pays 100% for these benefits, including:

- Up to five face-to-face EAP counseling sessions per issue per family unit per contract year from licensed EAP professional counselors.
- 24/7 Crisis Hot Line
- Identity Theft Services: Employees and family members receive unlimited phone consultation for identity theft recovery, support, and prevention.
- Cascade Personal Wellness Program: Wellness coaches offer support, information and referrals as needed and provide phone and email access for help in dealing with the following issues:
  - fitness and exercise
  - weight management
  - stress reduction
  - smoking cessation
  - sports performance
  - life balance
  - chronic conditions.
- Wellness tip sheets and other education materials are available to support you and your family members who wish to make changes in health behaviors.
- Health Risk Assessment (HRA). This can be accessed through the following websites: www.wellcall.com, or, www.cascadecenters.com. Cascade Centers can also be reached at **(503) 639-3009**. To use this service, employees and dependents must initially create an account using the company password “OES”. They will then be able to set up a user name and password of their own choosing.

MEAL PROGRAM

During the academic year, employees enjoy one free meal during the work day, courtesy of OES.

EXTENSION PROGRAM

Extension Program Employees with children enrolled in the Lower School and Middle School may use the Extension Program Services for their children as follows:

1. In Lower School, the first eight hours of drop-in home base per month per child is at no charge during the academic year. Please provide 24 hours of notice. Unused hours are not bankable. In the case of two parents who work at OES,this benefit is per child rather than per parent.
2. The Middle School Extension Drop-in Program is free of charge.
3. Employees receive 20% off after school classes. After school class discounts are automatically applied by the Extension Office. If the employee receives financial aid, the benefit will be increased to a 50% discount automatically applied by the Extension Office. Private lessons do not apply.
4. Employees that work during the summer receive 50% off summer classes. Employees that do not work in the summer receive 20% off summer classes. Summer class discounts should be applied by employees during the registration process by applyng a waiver code at check-out. Waiver codes will be issued by contacting the Extension Office. Summer flexible tuition opportunities and procedures will be announced each year. Private lessons do not apply.

Contact the Extension Program at extension@oes.edu for more information.

MATCHING RETIREMENT PLAN - AIG

OES offers a 403(b) retirement plan with a generous employer match through VALIC. The School contributes 7.5% when you contribute at least 5% of your gross monthly income to the plan and 4% when you contribute at least 2.5%.

Regular employees who have completed one hour of service and work at least 1000 hours per calendar year are eligible for enrollment in the plan.

Investment advisors Cecile Nguyen (Cecile.Nguyen@aig.com) and Thomas Grover (thomas.grover@aig.com) can help you enroll anytime online at www.VALIC.com.

TUITION REMISSION

Eligibility: Regular employees working at least .75 FTE. All regular employees working at least .75 FTE are entitled to up to 50 percent tuition remission (pro-rated to less than 50 percent if the total needed school-wide for tuition remission exceeds 3.5 percent of gross tuition) for up to two admissions eligible children attending OES. Any employee eligible for tuition remission who demonstrates a need for flexible tuition in excess of the remission amount may apply for flexible tuition through the standard application process. Employee parents who do not qualify for tuition remission may similarly apply for flexible tuition through the standard application process available to all OES families. See the OES Employee Handbook for further details.

PAID LEAVE BENEFITS

Please review the employee handbook for additional information.

BENEFITS CONTACT INFORMATION

If you have questions, contact the appropriate entity or person listed in the following directory.

BENEFIT	PROVIDER / CONTACT	PHONE	EMAIL / WEBSITE
Human Resources	Veena Iyengar	(503) 416-9482	iyengarve@oes.edu
	Tammy Stotik	(503) 416-9382	stotikt@oes.edu
Health	Providence Health	(503) 574-7500	www.providence.org/healthplans
Medical Plan Assistance (provider search, billing assistance, pricing)	Alight-Personal Health Pro Services	(800) 513-1667	https://member.alight.com/ MyHealthPro@alight.com
	Nicole Heinrich	(800) 513-1667 x2854	Nicole.Heinrich@alight.com
Dental	Willamette Dental	(503) 952-2000	www.willamettedental.com
	Kaiser Permanente	(503) 813-2000	www.kaiserpermanente.org
	Delta Dental	(877) 277-7280	www.modahealth.com
Vision	VSP	(800) 877-7195	www.vsp.com
Life, AD&D, Long Term Disability	Sun Life	(800) SUN-LIFE (786-5433)	www.sunlife.com
Long Term Care (grandfathered plan)	Transamerica	(800) 338-0257	www.transamerica.com
HSA / HRA Administrator, Flexible Spending Account (FSA)	Health Equity	(877) 694-3942	www.healthequity.com
Retirement	Cecile Nguyen	(503) 310-8522	Cecile.Nguyen@aig.com
	Thomas Grover	(360) 852-1082	Thomas.Grover@aig.com
EAP / Wellness	Cascade Centers	(503) 639-3009	www.cascadecenters.com
Global Travel Services	Assist America	(800) 304-4585	www.assistamerica.com
OES Benefits Website (Enrollment Forms and Documents)	Veena Iyengar	(503) 416-9482	www.oes.edu/contacts/employment.html
Benefits Questions	benefits@oes.edu		

NOTICES, SPECIAL RIGHTS, & PRIVACY

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents due to other coverage, you may be able to enroll later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards it) if you request enrollment within 31 days. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll later if you request enrollment within 31 days of the event. To request special enrollment or obtain more information about your Special Enrollment Rights, contact HR. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan. There are also other ways of proving you have creditable coverage. Please contact Human Resources if you need help demonstrating creditable coverage.

PRIVACY POLICY

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed. For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowlegement indicating that you received the Notice of Privacy Practices. If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated. Contact Human Resources for a copy of our health plans' Notice of Privacy Practices.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

As required by the Women's Health and Cancer Rights Act of 1998, this plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your plan administrator for more information.

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, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	**CALIFORNIA**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA Medicaid

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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

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

LOUISIANA Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY Medicaid and CHIP	UTAH Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OKLAHOMA Medicaid and CHIP	**VERMONT Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON Medicaid	**VIRGINIA Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
PENNSYLVANIA Medicaid	**WASHINGTON Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
RHODE ISLAND Medicaid and CHIP	**WEST VIRGINIA Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NEW YORK Medicaid	**WISCONSIN Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
NORTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
NORTH DAKOTA Medicaid	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Important Notice from Oregon Episcopal School Group Health Plan 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 Oregon Episcopal School Group Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Oregon Episcopal School Group Health Plan has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 Oregon Episcopal School Group Health Plan coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current Oregon Episcopal School Group Health Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Oregon Episcopal School and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November 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 Oregon Episcopal School Group Health Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 1, 2021
Name of Entity/Sender:	Oregon Episcopal School / Human Resources
Address:	6300 SW Nicol Road, Portland, OR 97223
Phone Number:	503-416-9382

NOTICE OF PRIVACY PRACTICES

Oregon Episcopal School
6300 SW Nicol Road
Portland, OR 97223

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Oregon Episcopal School (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "Protected Health Information." Generally, PHI is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearing house, a health plan, or your employer on behalf of the group health plan from which it is possible to individually identify you and that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please see the contact information at the bottom of this notice.

EFFECTIVE DATE

This Notice is effective October 1, 2021.

OUR RESPONSIBILITIES

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and make the new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make a material change to this Notice, we will provide you with a copy of our revised Notice of Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- ***For Treatment***

  We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

- ***Payment***

  We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

- ***For Health Care Operations***

  We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

- ***Treatment Alternatives or Health-Related Benefits and Services***

  We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

- ***To Business Associates***

  We may contract with individuals and entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide the services, our Business Associates will receive, create, maintain, transmit, use, and/or disclose protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization

management, subrogation, or pharmacy benefit management, but only after the Business Associate enters into a Business Associate contract with us.

- ***As Required by Law***

  We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

- ***To Avert a Serious Threat to Health or Safety***

  We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

- ***To Plan Sponsors***

  For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- ***Organ and Tissue Donation***

  If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- ***Military***

  If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

- ***Workers' Compensation***

  We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

- ***Public Health Activities***

  We may disclose your protected health information for public health activities. These activities generally include the following:

  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

- ***Health Oversight Activities***

  We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- ***Lawsuits and Disputes***

  If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

- ***Law Enforcement***

  We may disclose your protected health information if asked to do so by a law enforcement official:

  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstance, we are unable to obtain the victim's agreement;
  - about a death that we believe may be the result of criminal conduct; and
  - about criminal conduct.

- ***Coroners, Medical Examiners, and Funeral Directors***

  We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

- ***National Security and Intelligence Activities***

  We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- ***Inmates***

  If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you health care; (2) to protect your health and safety and the health and safety of others; or (3) for the safety and security of the correctional institution.

- ***Research***

  We may disclose your protected health information to researchers when:

  - the individual identifiers have been removed; or
  - when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

- ***Government Audits***

  We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***

  When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

- ***Personal Representatives***

  We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

  - you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
  - treating such person as your personal representative could endanger you; and
  - in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- ***Spouses and Other Family Members***

  Subject only to limited exceptions, we will send all mail to you. This includes mail that relates to your spouse and other family members who are covered under the Health Plan, and includes mail with information on the

use of Health Plan benefits by the employee's spouse and information on the denial of any Health Plan benefits to the employee's spouse and other family members. If we agree to your request regarding Confidential Communications below, we will send mail as provided by the request.

- ***Authorizations***

  Other uses or disclosures of your protected health information not described above will only be made after obtaining your written authorization. For example, subject to specific conditions, we will not use or disclose psychiatric notes about you; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information. You may revoke your authorization at any time, so long as you make the revocation in writing. Any revocation of authorization will only be effective as to future authorizations. It will not affect the authorizations as to any information that was used or disclosed in reliance upon your prior authorization.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

- ***Right to Inspect and Copy***

  You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

  To inspect and copy your protected health information, you must submit your request in writing to the contact information at the bottom of this notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

  We will generally respond to your request within 30 days after it is received, and if we need additional time to process your request we will let you know during the initial 30-day period.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the contact located at the bottom of this notice.

- ***Right to Amend***

  If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend your information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, your request must be made in writing and submitted to the contact at the bottom of this notice. In addition, you must provide a reason that supports your request.

  We will generally respond to your request within 60 days. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - is not part of the medical information kept by or for the Plan;

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- ***Right to an Accounting of Disclosures***

You have a right to an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purpose of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the contact at the bottom of this notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to Request Restrictions***

You have the right to request a restriction or limitation on your on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes or carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the contact at the bottom of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or booth; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

- ***Right to Request Confidential Communications***

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the contact at the bottom of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- ***Right to Be Notified of a Breach***

  You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

- ***Right to Receive a Paper Copy of This Notice***

  You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice, please see the contact information at the bottom of this notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact.

Oregon Episcopal School
Attn: Human Resources Department
6300 SW Nicol Road
Portland, OR 97223
503-416-9382

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.