2023 Employee Benefits Guide

Bethel University

Bethel University

Welcome to your Benefits

Welcome to the 2023 Bethel University Employee Benefits Guide. This guide offers you and your family members a look into your comprehensive benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage options for you and your family. We have included brief descriptions of our benefit offerings and the cost. If you have any questions, please contact the Human Resources Department at 574.807.7396.

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Enrollment

Benefits Eligibility

Please note that spouses who are eligible for coverage under their employer's medical plan are not eligible to be covered under the Bethel University Medical Plan. This only applies to the medical plan.

Dependent Eligibility

In addition to benefits for employees, Bethel also sponsors benefits for employee's family members. An employee's lawful spouse, as well as children and legal dependents are all eligible for benefit plan coverage, based on the guidelines outlined in this booklet and the plan certificates. Please read the plan eligibility rules carefully to verify whether your loved ones qualify for dependent benefit coverage.

Dependents defined as:

- An employee's lawful spouse (please see note above)
- An employee's child, who is:
  - Less than 26 years of age
  - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap

Dependent Specifications

Please be advised that correct Social Security Numbers and dates of birth are required for enrollment of a new dependent. If you do not have this information at the time you are enrolling your dependent, there may be a delay in coverage.

Enrollment Changes

As long as you remain eligible, your benefit elections will be in place until December 31st , 2023. However, you may make mid-year changes if you have a qualifying event. Examples of qualifying events that allow you to change your benefit elections during the year are:

- Marriage or divorce
- Birth, adoption or change in the custody of a child
- Death of your spouse or dependent child
- A change in the employment status of a spouse, impacting your benefit eligibility
- A change in your dependent's status (due to age or eligibility for medical coverage through his/her own employer)
- A significant reduction in the average number of hours worked

If you have a qualifying event, you must change your benefit elections within 30 days of the event. If you do not make a change within 30 days, you must wait until the next open enrollment period. Please contact Human Resources for more information.

Medical/RX Plan

DESCRIPTION OF BENEFITS		BETHEL UNIVERSITY HDHP 3000	
PLAN PROVISIONS			
Annual Medical Deductible		$3,000 Per Person $6,000 Per Family	
Annual Medical Out of Pocket Maximum The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.		$4,000 Per Person Maximum $8,000 Per Family	
Amounts in Excess of Negotiated Rates/Reasonable and Allowed Charges		For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable and Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable and Allowed amount, except as specifically stated in this document. Any amounts in excess of the Reasonable and Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of- Pocket Maximum.
Lifetime Maximum		None	
Dependent Coverage		To age 26	
MEDICAL SERVICES			
All plan benefits shown as a percentage of Eligible Charge.			
	Do Services Require Prior Authorization?	**Member Pays**	
		Participating Providers	**Non-Participating Providers**
PHYSICIAN SERVICES			
Telemedicine	No	$49 Copayment per visit	Not Covered
Primary Care Office Visits	No	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible
Specialist Office Visits	No	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible
Other Services performed in the office - including Diagnostic Services, Office Surgery and Radiology Services, Laboratory and Pathology (Prior Authorization rules for any other service performed in the office, please refer to the Diagnostic Services section).	No	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Urgent Care	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
MATERNITY			
Physician Services	No	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible
PREVENTIVE CARE			
BENEFITS FOR CHILDREN			
Newborn Circumcision	No	No Copayment	No Copayment
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "well-child visits") 5 to 17 years (1 per year, "well-child visit")	No	No Copayment	No Copayment
Well Child Care Immunization (recommended by Bright Futures Project)	No	No Copayment	No Copayment
Well Child Care Lab Tests (recommended by Bright Futures Project)	No	No Copayment	No Copayment
		Member Pays	
		Participating Providers	**Non-Participating Providers**
ADULT PREVENTIVE SCREENING/TESTING			
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No	No Copayment	No Copayment
Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No	No Copayment	No Copayment
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No	No Copayment	No Copayment
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	No	No Copayment	No Copayment
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	No	No Copayment	No Copayment

Medical/RX Plan

	Do Services Require Prior Authorization?	Member Pays	
		Participating Providers	Non-Participating Providers
WOMEN'S PREVENTIVE CARE SERVICES			
Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables) (Pharmacy - birth control pills, diaphragms)	No	No Copayment	No Copayment
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment	No Copayment
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment	No Copayment
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No	No Copayment	No Copayment
Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. (Reimbursement of Non-Participating breastfeeding supplies up to the amount of $200).	No	No Copayment	No Copayment
HOSPITAL/FACILITY SERVICES			
Inpatient Room & Care – semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Outpatient / Ambulatory Surgery Services & Birthing Centers	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	Yes (if at a hospital)	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Emergency Room Services	No	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
DIAGNOSTIC SERVICES			
Laboratory Services			
Non Hospital Based	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Hospital Based	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Radiology & Radiation Oncology Services			
Non Hospital Based	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Hospital Based	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
CT/MRI/MRA/PET Scan			
Non Hospital Based	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Hospital Based	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER			
INPATIENT			
Hospital & Facility Services; semi-private room rate	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Psychiatrist & Psychologist Services	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
OUTPATIENT			
Psychiatrist & Psychologist Services	Yes (if at hospital)	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Psychological Testing	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
OTHER SERVICES			
Allergy Testing (including serums, injections, and administration)	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Ambulance (Ground & Air)	Yes (Non-emergent)	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Chemotherapy	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Dialysis and Supplies	Yes	20% Coinsurance after Annual Deductible** Plus amounts that exceed the Reasonable and Allowed Charge	
Durable Medical Equipment (including Orthotics/Prosthetics)	Yes (If greater than $500 charge per single item)	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Enteral Nutrition Therapy	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge

Medical/RX Plan

	Do Services Require Prior Authorization?	Member Pays	
		Participating Providers	Non-Participating Providers
Home Health Services (Maximum of 100 visits per year)	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Home Infusion Services	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Hospice Services	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Human Growth Hormone, Genetic Testing/Counseling, Other	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Physical/Occupational/Speech Therapy (Non Hospital Based)	Yes	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Temporomandibular Joint Disorder (TMJ) Maximum of $500 per lifetime	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
ALTERNATIVE CARE SERVICES			
There is a combined benefit year benefit maximum of 20 visits for Alternative Care Services.			
Acupuncture	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Chiropractic Care	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Naturopathy	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
Massage Therapy	No	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Charge
** Participating Deductible applies.			
Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable and Allowed reimbursement level for Non-Participating Providers as established by the Plan.			
Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.			

PHARMACY PROVISIONS ***(Please refer to the ID Card for Pharmacy Benefit Information)***		**Participating Pharmacies**	**Non-Participating Pharmacies**
PHARMACY BENEFITS		**Member Pays**	
Annual Pharmacy Deductible		$3,000 Per Person $6,000 Per Family Combined with Medical Annual Deductible	Not Applicable
Annual Pharmacy Out of Pocket Maximum		$4,000 Per Person Maximum $8,000 Per Family Combined with the Medical Annual Out of Pocket Maximum	Not Applicable
Lifetime Maximum		None	
Preventive Prescription Services			
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.			
Prescription Drugs Pharmacy Retail - up to a 30 day supply		Generic - $0	Not Covered
Non-Preventive Prescription Services			
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.			
Prescription Drugs Pharmacy Retail - up to a 30 or 90 day supply		Generic, Preferred Brand and Non- Preferred Brand - 20% Coinsurance after Annual Deductible	Not Covered
Prescription Drugs Pharmacy Mail Order - up to a 90 day supply		Generic, Preferred Brand and Non- Preferred Brand - 20% Coinsurance after Annual Deductible	Not Covered
Specialty Drugs		Not Covered	Not Covered
This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.			

**If services other than preventive care as outlined by the US Preventive Services Task Force Recommendations are obtained during the visit, coinsurance, and/or deductible may apply.*

Medical/RX Plan

Medical Plan Details

Bethel University offers benefit eligible employees the option to enroll in a Qualified High Deductible Health Plan thru Hawaii Mainland Administrators (HMA).

Your HSA-Qualified Health Insurance Plan

- Covers preventive care, such as your annual routine physical and related preventive tests at 100% with no deductible or copayment
- Have an unlimited lifetime maximum benefit
- Meets and exceeds the minimum coverage requirement under the Affordable Care Act
- Is administered by HMA, and uses a combination of the PNOA and PHCS Prac & Anc networks for routine physician care.

  To find physicians within the network:

  - Please visit www.multiplan.com/PHCSpracanc
  - This list is not a comprehensive list. You can call your provider and ask if they are in-network with the PHCS Practitioner and Ancillary network.
  - If your provider does not participate in either of the networks, you can go to "Nominate a Provider" under the PNOA website, www.pnoa-ppo.com and submit a nomination form. In the notes section of the form write in "Bethel". The PNOA team will then reach out to that provider to see if they are interested in joining the network.

HMA + Advanta online services are fast, easy, and free with convenient access to tools and resources such as (see page 8 for additional details):

- Claim status (including copies of Explanations of Benefits - EOBs)
- Status of medical deductibles and out-of-pocket amounts
- Frequently used forms
- Ordering ID cards (duplicates or replacements)
- Access to an ADVANTA advocate and telemedicine

ADVANTA

- ADVANTA is HMA's member advocacy service. ADVANTA will be your primary point of contact when you need to receive medical care in a hospital or outpatient facility.
- ADVANTA specialists are available 24/7/365 to assist members prior to, during, and after receiving care in a hospital or outpatient facility.

If you have questions or problems, you can contact HMA at 866-206-7920.

Medical/RX Plan

Additional Information

Preventive Benefits

As a reminder, our health plan covers routine and preventive care at 100% with no deductible or copayment. This includes your annual routine physical, routine and preventive mammograms, pap tests, PSA tests, immunizations, etc. Please note that claims must be coded by your doctor as "routine and preventive" rather than "diagnostic" in order to be covered at 100% under the Preventive Care benefit.

Pharmacy Benefits

3 ways to obtain prescriptions:

- **Through your prescription benefit True Rx (use your insurance card)**
  - ❖ Your Pharmacy Benefit Manager (PBM) is True Rx.
  - ❖ To register for an online account, visit truerx.com/member-portal. This will allow you to find In-Network pharmacies, know which medications are covered, price compare, and download the True Rx app. When entering the Member ID, drop the last 2 digits of number listed on your card.
  - ❖ **Mail Order Prescription Program**
    - o The Mail Order program thru WB Rx Express is a great way to help you save money on medications you take every day. Once you begin using the mail order plan, getting refills is easier than waiting in line at the store, and it can save you money. Get started in two easy steps:
    - o **Step 1: Obtain a prescription** from your doctor for a 90-day supply, plus 3 refills.
    - o **Step 2: Visit wbrxexpress.com or call 833-391-0126**. Have your prescription handy and the name and phone number of your doctor.
  - ❖ **Preventative Drug List**
    - o There are some medications that are covered as preventative. Covered prescriptions will be filled with no out-of-pocket costs.
- **Good Rx**
  - ❖ Employees are able to utilize the free GoodRx program to shop for prescription drugs. If you use the GoodRx coupon or app to purchase your prescriptions, it will be run outside of the prescription drug plan through True Rx. However, you are able to submit a manual claim to have that amount count towards your Deductible and Out-Of-Pocket accumulators through HMA. You can find the form by going to MyBethel > Resources > Human Resources > Benefits. Scroll down on the right side until you find Good Rx Deductible Credit Claim Form.
- **SHARx (see next page)**

Medical/RX Plan

SHARx

What is SHARx?

SHARx is a pharmacy advocacy solution offered by Bethel University. This program was created to extend advocacy program benefits to employees like you. Their role is to help facilitate the advocacy onboarding process for each eligible member of the Bethel University health plan and to provide access for all high-cost medications.

Who is eligible?

This program is available to members enrolled in the health plan. **If you are currently on a high-cost medication ($350+ per month), you will be required to use the SHARx program.**

What are the costs?

There are no costs to you. Bethel pays for 100% of the cost of this service for all members covered on the Bethel University medical plan. Prescriptions obtained thru SHARx will be free to you and your family.

What to expect

It is important to note that this is not an overnight solution and usually takes from two to four weeks on average to implement your cost savings, depending on outside circumstances of doctor cooperation, ease of communication, and understanding.

Please understand that this service is not insurance. SHARx is not an insurance company and they are not offering insurance. They are a prescription drug advocacy firm helping people like you lower the cost of their prescription and medications.

How to sign up?

During onboarding, if you have been identified as having a high-cost medication, you will receive a welcome email from SHARx. After receiving the email, please follow the instructions in the email:

- Click on the custom link in the email to create an account on the SHARx platform
- Validate your identity and set up a user account for the website
- After logging in, you can verify the prescription information on file for you and your dependents
- Complete a “Request for Advocacy” and the SHARx team will begin the process

If you do not receive a welcome email or are prescribed a high-cost medication in the future, please email sharx@sharxplan.com or call 314-451-3555

Medical/RX Plan

Understanding Health Insurance Terminology

What is a deductible?

It is a set dollar amount determined by your plan that you will pay out of your pocket if you have claims. The deductible accumulates on a calendar year basis and is reset at $0 each January 1.

What is coinsurance?

After your deductible is met, you then pay a share of your eligible medical expenses. This is called coinsurance. For Bethel's Plan you pay 20% of the charges after the deductible for each covered person on your plan up to the maximum of $4,000 ($8,000 for family coverage).

What is my out of pocket maximum?

This is the maximum amount (deductible and coinsurance combined) you are responsible to pay per calendar year. It is $4,000 per person ($8,000 family) for covered services and does not include amounts exceeding the Reasonable and Allowed amount.

2023 Bi-Weekly Medical Payroll Deductions	Medical Plan
Employee Only	$10.00
Employee + Spouse	$80.50
Employee + Children	$77.50
Employee + Family	$99.00

As a reminder, spouses who are eligible for coverage under their employer's medical plan are not eligible to be covered under the Bethel University Medical Plan. This only applies to the medical plan.

Health Savings Account

Understanding A Health Savings Account

- **What is an HSA?**

It is your personal tax-exempt bank account used to pay for out-of-pocket medical, dental and vision expenses.

- **Am I eligible to establish an HSA?**

Our plan is specially designed to meet the IRS requirements that allow you to establish and make contributions to an HSA, although you are not required to do so.

You cannot open an HSA or make contributions to an HSA if you are enrolled in a health plan that is not a qualified "High Deductible Health Plan" ("HDHP") as defined by the IRS. A qualifying HDHP is one that does not reimburse covered medical expenses until a maximum annual deductible established by the IRS is met.

- **You are not eligible for an HSA if you are:**
  - Covered under another medical plan that is not an HDHP;
  - Entitled to (eligible for AND enrolled in) Medicare benefits; or
  - Eligible to be claimed on another person's tax return.

- **Who holds my HSA funds?**

The HSA is an individual bank account owned by you. **After you open a Health Savings Account at the bank of your choice (Bethel does not set this up for you)**, your pre-tax payroll deductions will be deposited into the account after you provide your HSA account info to Human Resources.

- **How and when do I make contributions to my HSA?**

You may have contributions direct deposited from your paycheck on a pre-tax basis. You may also make contributions directly into your HSA on an after-tax basis. You will receive a Form 1099 from your HSA bank annually that will show your annual HSA contribution. You then report your HSA contribution by completing Form 8889 with your annual federal income tax return.

- **How do I access my HSA funds?**

The bank will provide you with a debit card and check book (if requested). Remember, in the event of an IRS audit, you are responsible for providing your receipts for services and other items purchased with money from your HSA.

- **What if I don't have enough money in my HSA account to pay for my medical expenses during the year which apply toward my deductible and coinsurance out-of-pocket?**

The good thing about an HSA is that it is flexible and allows you to add additional money (up to the annual max) or change your contribution during the year. You can either request a change in the amount of your pre-tax payroll deduction during the year, or you can deposit after-tax money and generally take a deduction when you file your taxes. Talk to your tax advisor about this option.

- **What can I spend my HSA funds on?**

The IRS allows you to use your HSA funds to pay for your out-of-pocket costs for qualified medical, dental, and vision expenses that are incurred after your HSA is established. Qualified expenses are those as defined by IRC Section 213(d). Visit https://www.irs.gov/pub/irs-pdf/p502.pdf for a list of allowed expenses. Amounts distributed from your HSA for any other reason are subject to income tax and an additional 20% penalty tax.

Health Savings Account

- **How much can I contribute to an HSA in 2023?**
  - $3,850 for individual coverage and $7,750 for family coverage
  - Individuals age 55 or older may be eligible to make a catch-up contribution of $1,000.

- **Important Information**
  - If your spouse has a separate HDHP plan and is contributing to a HSA, you need to ensure your combined contributions between the two accounts do not exceed the IRS Family Maximum.
  - If you have coverage through Bethel as the employee, you will have to have a HSA in your name. You cannot deposit funds into your spouse's HSA.

- **What if I enroll in an HSA in the middle of the year?**

Your HSA contributions are generally determined on a monthly basis. However, if you enroll in an HSA mid-year, you are allowed to make a full year's contribution, provided you are eligible on Dec. 1 of that year and you remain eligible for HSA contributions for at least the 12-month period following that year. You cannot reimburse yourself for expenses incurred prior to opening your account.

- **Who is eligible to use my HSA funds?**

You can use your HSA funds to reimburse Qualified Medical Expenses incurred by you, your spouse,

and your tax dependents (which is not necessarily the same as those enrolled in your medical plan), as long as the expenses are incurred after the date that your HSA is established.

- **What happens to my HSA funds if I leave?**

You take your HSA account and funds with you because it's your personal bank account. Remaining HSA funds may continue to be spent on qualified out-of-pocket medical, dental, and vision expenses.

Dental Insurance

PARAMOUNT
Affiliate of ProMedica

Paramount Dental (Formerly HRI)

You have the option to enroll in a comprehensive dental insurance plan, administered by Paramount. You do not need to be enrolled in the health insurance plan to enroll in dental insurance.

Type of Service	In Network
Calendar Year Deductible Single Family	 $0 $0
Annual Dental Maximum per Person	$1,000
Preventive Services Oral Exams & Cleanings, Bitewing X-rays & Fluoride Treatments, Sealants (children up to age 14)	100%
Basic Services Fillings, Simple Extractions, X-rays, Periodontics	80%
Major Services Major Restorative Services, Crowns, Bridges, Dentures	50%

This is a partial listing of benefits and services only. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of the Dental Certificate.

2023 Bi-Weekly Dental Payroll Deductions	Dental Plan
Employee Only	$9.45
Employee + Spouse	$19.37
Employee + Children	$16.05
Employee + Family	$28.65

Dental Insurance

Paramount Dental

You may utilize the dental provider of your choice, and the benefit level (100%, 80%, or 50%, depending on the type service) is the same regardless of the provider being considered in or out of network. However, by using a provider participating in the Paramount Dental Network, you may have lower out-of-pocket costs due to pre-negotiated rates and maximum allowable costs in the provider contract.

If you utilize a dental provider that does not participate in the Paramount Dental Network, you are responsible for any amount charged by the provider which exceeds the reasonable and customary (R&C) allowable fee. The R&C fee is the amount the insurance company considers the reasonable charge based on the type of service and the geographical area where you receive treatment.

Note: Even if you use a participating dentist, you are always responsible for your deductible and coinsurance amount.

You may visit www.insuringsmiles.com/findadentist to find participating providers in your area. **Click on "Dental"**

1. **Click "Employer & Individual Plans"**
2. **Fill in your dentist's name or choose a specialty**
3. **Fill in your zip code**

Vision Insurance

Metlife

You have the option to enroll in a vision insurance plan through Metlife. Your plan uses the VSP Choice network. You may visit www.vsp.com to find participating providers in your area. No ID Card is necessary for your provider to file claims with Metlife.

Benefits When Using a Participating VSP Provider		Copay
Well Vision Exam	• Focuses on your eyes and overall wellness • One every calendar year	$10
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance • Every other calendar year	$25
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35 – 40% off other lens enhancements	$55 $95 - $105 $150 - $175
Contacts (in lieu of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60

2023 Bi-Weekly Vision Payroll Deductions	Vision Plan
Employee Only	$3.38
Employee + Spouse	$5.70
Employee + Children	$5.82
Employee + Family	$9.38

Life Insurance

Basic Life and AD&D Insurance

Bethel University provides full-time employees with a $50,000 Basic Life and AD&D benefit through Reliance Standard. Bethel University provides this benefit to you at no cost.

Supplemental Term Life Insurance

Term Life insurance is an important part of your benefits. It's not easy to think about, but an unexpected death in the family could burden the surviving family members with large expenses on less income. Purchasing additional term life insurance could assist your loved ones with mortgage payments, funeral expenses, medical expenses, childcare expenses, etc.

Guaranteed issue amounts are available to you one time as a new hire at your initial benefits eligibility. If you are not a new hire electing benefits for the first time, you must complete a health questionnaire, and coverage is not guaranteed.

Term Life Benefit*	Employee	Spouse	Dependent Child
*Term Life: Benefit paid to designated beneficiary upon death of insured. Coverage is for a certain term and has no cash value.	Choice of $10,000 increments. Not to exceed 7 times your salary. Employees age 70 and older, maximum benefit is $50,000.	Choice of $5,000 increments. Employee must elect coverage for spouse to be eligible. Not to exceed 100% of employee elected amount.	$2,500 (6 Months to Age 26; 14 days to 6 Months limited to $250). Employee must elect coverage for child(ren) to be eligible.
Minimum Amount	$10,000	$5,000	$2,500
Maximum Amount	$500,000 (or 7x's Annual Salary)	$250,000	$10,000
Guarantee Issue* *Available amounts shown are offered to any eligible applicant (employee and dependent(s) without regard to health status if you enroll during the initial new employee waiting period. No medical questions are asked on the application unless the amount applied for exceeds the amounts shown.	$200,000 of coverage is available on a guaranteed acceptance basis within your new employee waiting period.	$50,000 of coverage is available on a guaranteed acceptance basis within your new employee waiting period. Guarantee Issue for spouses of employees age 70 and over is $10,000	No health questions required for eligible children.

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Life Insurance

AD&D Benefit*	Employee	Spouse	Dependent Child
Amount *AD&D (Accidental Death & Dismemberment): Double indemnity for accidental death or a percentage of the benefit payable per covered non-work-related accidental injury.	The benefit amount is equal to the life amount elected by you. Cost included in the schedule.	Employee must elect coverage for dependent to be eligible.	Employee must elect coverage for dependent to be eligible.

Benefit Reduction	Employee	Spouse	Dependent Child
Benefits will reduce:	• 35% at age 65 • Add'l 25% of the original amount at age 70 • Add'l 15% of the original amount at age 75 • Benefits terminate at age 80 or retirement, whichever is first.	• 35% at employee age 65. • Benefits terminate when the employee reaches age 70.	N/A

Additional Benefits	
Accelerated Death Benefit	Cash advance against the death benefit available if insured has a terminal illness.
Portability	You may be eligible to continue your term insurance coverage when employment ends by paying the required premiums.
Conversion	You may apply to convert your term life insurance to a whole life policy at termination of employment.

Eligibility	Employee	Spouse & Dependents
	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity* on the day coverage takes effect. *Period during which a dependent is confined to a health care facility and/or unable to perform what would be considered regular.

Disability Insurance

Long Term Disability (LTD) – Plan Features

Long Term Disability insurance helps protect you and your family's income in the event of a long-term illness or disability. The university provides all full-time employees with Long Term Disability coverage at no cost.

- LTD benefits begin on the 181st day of a disability due to an injury or illness.
- Your monthly benefit is equal to 60% of your salary to a maximum of $5,000.
- The monthly benefit is reduced by Social Security or other income you receive.
- LTD benefits continue to age 65, provided you remain disabled.
- Pre-existing condition limitation: If you become disabled due to a pre-existing condition during the first 12 months that you are covered, the benefit will not be paid.

Payroll Deductions

Medical

2023 Bi-Weekly Medical Payroll Deductions	Bethel HDHP 3000
Employee Only	$10.00
Employee + Spouse	$80.50
Employee + Children	$77.50
Employee + Family	$99.00

Dental

2023 Bi-Weekly Dental Payroll Deductions	Dental Plan
Employee Only	$9.45
Employee + Spouse	$19.37
Employee + Children	$16.05
Employee + Family	$28.65

Vision

2023 Bi-Weekly Vision Payroll Deductions	Vision Plan
Employee Only	$3.38
Employee + Spouse	$5.70
Employee + Children	$5.82
Employee + Family	$9.38

Supplemental Benefits

Accident Insurance

- Offered through Unum
- Pays a lump sum benefit directly to you for accidental injuries
- This benefit can help offset the out-of-pocket expenses that health insurance doesn't pay, such as deductibles and coinsurance in the case of an accident.
- A snapshot of conditions covered are listed below.

Description	Option 1	Options 2
Accidental Death	Primary Insured - $50,000 Spouse, if covered - $25,000 Child(ren) if covered - $12,500	Primary Insured - $75,000 Spouse, if covered - $37,500 Child(ren) if covered - $18,750
Hospital Confinement	$1,000 admission / $200 per day	$1,500 admission / $300 per day
Intensive Care	$500 admission / $200 per day	$500 admission / $300 per day
Ambulance Services	$200 Regular $600 Air	$300 Regular $1000 Air
Accident Physician Treatment	$100	$150
X-Ray	$100	$150
Dislocation or Fracture	Primary Insured - up to $4,000 Spouse, if covered – up to$4,000 Child(ren), if covered – up to $4,000	Primary Insured - up to $6,000 Spouse, if covered – up to $6,000 Child(ren), if covered – up to $6,000
Emergency Room Services	$200	$300

2023 Bi-Weekly Accident Payroll Deductions	Accident Plan 1	Accident Plan 2
Employee Only	$4.65	$6.36
Employee + Spouse	$7.86	$10.68
Employee + Children	$11.46	$16.37
Employee + Family	$14.67	$20.69

Supplemental Benefits

Critical Illness Insurance

- Offered through Unum
- Pays money directly to you when you are diagnosed with specific critical illnesses
- This money can help you pay out-of-pocket medical expenses and help with other out-of-pocket costs that aren't covered by health insurance in the event of a designated critical illness.
- **Critical illnesses that are covered under this policy are:**
  - **Heart Attack**
  - **Stroke**
  - **Major Organ Transplant**
  - **End Stage Renal Failure**
  - **Cancer – Invasive, Non-invasive (25%), and skin cancer ($500)**
  - **Coronary Artery Disease – Major (50%), Minor (10%)**
  - **Progressive Diseases (25%) – ALS, Dementia (including Alzheimer's), MS, and Parkinson's**

2023 Bi-Weekly Critical Illness Payroll Deductions

Option 1 ($10k)	Non-Tobacco		Tobacco	
Employee Age	EE or EE+CH	EE+SP or Fam	EE or EE+CH	EE+SP or Fam
18-29	$2.62	$4.36	$3.22	$5.26
30-39	$4.05	$6.51	$5.90	$9.28
40-49	$6.59	$10.32	$10.61	$16.35
50-59	$11.02	$16.96	$17.67	$26.94
60-69	$23.48	$35.66	$34.14	$51.65
70+	$39.54	$59.75	$50.81	$76.65

Option 2 ($20k)	Non-Tobacco		Tobacco	
Employee Age	EE or EE+CH	EE+SP or Fam	EE or EE+CH	EE+SP or Fam
18-29	$4.38	$7.00	$5.58	$8.80
30-39	$7.24	$11.29	$10.93	$16.83
40-49	$12.31	$18.90	$20.34	$30.95
50-59	$21.18	$32.20	$34.47	$52.14
60-69	$46.10	$69.58	$67.42	$101.56
70+	$78.22	$117.76	$100.74	$151.55

Additional Info

403(b) Retirement Plan

Bethel's 403(b) plan is through TIAA. Employees can contribute both pre-tax and post-tax (Roth) dollars into the plan. View your account, update your beneficiaries, and change your investment selections at www.tiaa.org. Changes can be made at any time during the year.

Service Days

Bethel encourages all staff members to utilize up to three paid Service Days per fiscal year to volunteer their time and talent in service to the community. These days must be scheduled (and approved) in advance and can be requested off using a leave request form.

Tuition Reduction Grant

Tuition remission is a benefit provided by Bethel University to all benefit-eligible employees (working at least 30 hours per week, year-round), their spouses and their dependents according to the provisions described in the Tuition Remission Policy. A degree earned with Tuition Remission assistance is limited to one earned undergraduate degree per family member (employee, spouse, dependent).

Bethel University also participates in the Tuition Waiver Exchange Program sponsored through the Council of Christian Colleges and Universities. More information about this program can be obtained by contacting the Office of the Vice President for Academic Services.

Be sure to watch your email and Bethel feed in March/April for the 2023-2024 TRG policy and form. If you miss the deadline for submitting your form, you will not be eligible for TRG benefits for the 2023-2024 academic year. No late applications are accepted.

2023 Holidays/Time Off

The 2023 Holidays with the day in parentheses of when the holiday will be recognized at Bethel:

New Year's Celebration (Mon, January 2)
Good Friday (Fri, April 7)
Memorial Day (Mon, May 29)
Independence Day (Tue, July 4)
Labor Day (Mon, September 4)
Fall Break (Thur & Fri Oct 5-6)
Day Before Thanksgiving (Wed, November 22)
Thanksgiving (Thur, November 23)
Day After Thanksgiving (Fri, November 24)
Christmas Eve (Fri, December 22)
Christmas Day (Mon, December 25)
Christmas Recess (Tue, Dec 26 – Sun, Dec 31)
New Year's Celebration 2023 (Mon, January 1)

Additional Info

Frequently Asked Questions (FAQs)

Standard Value Based Pricing Plans Only

Q: What is a Value Based Pricing Plan?

A: Your health plan has eliminated Preferred Provider Networks (PPO) for all facility (hospitals), ambulance and dialysis services allowing you to access any provider of these type you so choose. All payments to these providers are based off a fair and reasonable reimbursement. For all remaining services, such as physician offices, lab, home health, etc. your plan works in much the same manner as your previous Plan. You are encouraged to seek services from a contracted PPO provider to lower your out-of-pocket costs.

Q: Can I only go to a Provider that is in network?

A: Your Plan includes a PPO network for non facility (hospital), ambulance and dialysis services. Examples of these providers include physicians, lab, home health, etc. For all facility (hospital), ambulance and dialysis services, there is no network. You have the freedom to go to any of these providers you choose who accepts the Plan.

Q: Who is Hawaii-Mainland Administrators (HMA)? Who is Advanta?

A: Hawaii-Mainland Administrators (HMA) is a Third Party Administrator (TPA). They have been hired by your employer to administer your health plan. HMA has a department called Advanta. Advanta provides support for members needing education and assistance in navigating their value-based health plan as well as assist in answering provider inquiries. Advanta is broken into 2 units, which specialize in assisting members, these are:

1. **Pre-Service Advocacy Services** - This important service under your plan occurs PRIOR to you receiving medical services. It is vital that members contact Advanta at the earliest possible point PRIOR to receiving care. When this occurs, your Advocate can work with you to obtain the best and most cost effective care possible. This service includes assistance in getting in with a provider who accepts the plan and its reimbursement. Remember to contact Advanta PRIOR to receiving any non-emergent care.

2. **Post-Service Advocacy Services** - This occurs when you are unable to contact Advanta prior to receiving the service. In this case you may receive an additional bill from the provider. If this occurs immediately contact Advanta who will then begin the process of rectifying your case.

Q: What should I do when I am calling my provider to set an appointment?

A: Have your ID Card with you when you make the call. When you call your provider to set your appointment let them know provide them the information on your ID Card – Plan ID#, Member ID# and Advanta at HMA phone number 866-206-7920. Request that they call Advanta at HMA in advance of your appointment to confirm eligibility, benefits and understand their reimbursement. If you are seeking services from a PPO covered provider and they ask you which PPO or Provider Network you are utilizing give them the name of the Network which is on the back side of your ID card. If you are seeking services from a Facility, ambulance or dialysis provider, tell them you have an open access plan.

Q: What should I do if my provider's office doesn't recognize my ID Card and won't take my insurance?

A: Firstly, as outlined in the last question & answer, we recommend that you call your provider to set your appointment in advance. This will alleviate potential issues before you arrive. If you do arrive at your provider's office and they don't recognize your ID Card and say they don't take your insurance ask for an office manager or billing representative and ask them to please call Advanta at HMA immediately at 866-206-7920 (back of ID card).

Q: What do I do if they still refuse to take my insurance and the situation is urgent?

A: If after trying the last step the doctor's office still refuses to take your insurance, to be seen they may require payment up front. If this is the case, and it's urgent, ask the provider for their cash price for the visit. Make sure you keep all receipts and submit a claim reimbursement form (located on HMA member portal) to HMA for reimbursement according to your benefits. If it is not urgent, please call Advanta at HMA at 866-206-7920 for guidance in rescheduling an appointment with another provider.

Q: Whom should I contact for questions about my benefits?

A: You should call Advanta at HMA at 866-206-7920.

Q: I have met my out of pocket maximum, why am I receiving a bill?

A: If you received a service that is subject to Value Based Pricing and a reimbursement agreement was not established between the provider and Advanta beforehand, it is possible that you will receive a balance bill. If this occurs, contact Advanta immediately. Your Post-Service Advocate will begin the process of rectifying your situation.

Additional Info

Q: What is a balance bill?

A: A balance bill is when a provider bills a member for the difference between what the health plan allows for a medical service versus what the provider chooses to charge. In essence, it's when the provider charges more than what the Explanation of Benefit (EOB) indicates is the patient responsibility. It is vital that members understand that a major contributor of skyrocketing healthcare costs are the massively inflated charges that providers can charge. Your Plan has been designed to address this issue by reimbursing providers based on a fair and reasonable basis. Understanding what a Provider is going to charge for a service is mandatory when it comes to lowering the unsustainable growing costs of healthcare.

Example: Your hospital charges are $100 and the plan allowable at 150% of Medicare is $70.00. If the facility provider bills you the $30 difference between the charged amount and the Plan allowable, they are balance billing. Deductibles, copays, and coinsurance are not examples of balance billing and you are still responsible for these cost sharing items.

Q: What should I do if I receive a balance bill?

A: If you receive a bill from a hospital or other medical facility, you need to compare it to the EOB that you received from the Third-Party Administrator. If you are asked to pay more money than what is shown as patient responsibility on your EOB, you need to call Advanta at HMA at 866-206-7920. The Advocate will likely need you to send the bill via email or fax.

Q: What happens when I contact Advanta at HMA about a balance bill?

A: The Advanta team will work with your provider directly regarding the balance bill. You will be updated along the way. In many cases the issue is resolved with little to no impact on the member. However, in certain cases, the provider may continue to demand the balance be paid. If this occurs, Advanta will work with you on the different options available.

Q: What should I do if a facility (like a hospital or outpatient center, etc) requests payment up front?

A: Do not pay anything other than your copay up front. The facility should call Advanta at HMA at 866-206-7920.

Q: What should I do if a Provider requires me to sign a document that states I'm fully responsible to pay the full charges in the event my insurance does not?

A: If a provider requires you to sign a document accepting financial responsibility for amounts not covered by your health plan, ask them to first provide you with the amount they plan to bill for the service. If the provider gives you the estimated cost of the visit and you are comfortable committing yourself to pay that amount then you may sign the document. If the provider refuses to give you the estimated charges or you do not feel comfortable committing yourself to paying the estimated charges you may have to cancel your service and reach out to an Advanta rep for assistance with rescheduling the visit. If the service is emergent the provider must render care in which case you do not have to sign the document.

Q: How do I know I've been balance billed?

A: If you receive a billing statement, verify the amount owed using your explanation of benefits from HMA under the section Member Liability Co-pay, Coinsurance or Deductible, if the amount on your billing statement is higher you have been balance billed. Please contact Advanta immediately to have a Member Advocate work on your behalf to get the bill resolved.

Q: What happens if I pay my bill in full?

A: If a balance bill occurs, do not pay it. Contact Advanta immediately and a Member Advocate will work directly with the facility so that you do not have to. You are only responsible to pay what is shown on your Explanation of Benefits (EOB).

Q: Do I need to set up arrangements to pay?

A: If you can't pay your responsibility in full please set up a payment plan with your provider just to cover your liability only if you don't know what that amount is with the provider. Please contact Advanta to discuss what you are liable for before proceeding with any arrangements.

Q: What if the facility calls and I receive continuous notices to make a payment?

A: Call Advanta and speak with a Member Advocate. Please provide them with the name and contact information of the person that is calling you. The Advocate will notify them that your bill is being disputed and negotiated for settlement. This will ensure that you are only responsible for the Patient Responsibility portion, as stated on your EOB.

IMPORTANT: It is important that you open any and all mail in order to check for any balance bills. If you receive a balance bill for any medical services, it is VERY essential that you contact Advanta at HMA at **866-206-7920**.

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