YOUR 2023

Benefits Snapshot

Open Enrollment is October 6-27.

What's New for 2023

We review our benefits program each year to ensure we are providing the plans and coverages that best meet the needs of you and your family.

Detailed benefit information can be found on **RSFBenefits.com**. The following are a few highlights of our 2023 offerings.

Easy Access to Benefits Info

You and your family members can easily access your benefits information whenever and wherever you need it at our benefits website, **RSFBenefits.com**. You also can download the Benefitplace™ app to complete your enrollment on your mobile device. Use the code "RSFBenefits".
Enrolling by telephone is NOT an option. All benefit elections must be submitted on the benefits website or Benefitplace™ app.

Pharmacy

Prescription drug coverage will continue to be part of all of the medical plans, administered by our new pharmacy provider, MedImpact, beginning in 2023. Teammates can expect some changes, especially in administrative processes and programs due to the change in administrators. You can view more details on **RSFBenefits.com**.

Flexible Spending Accounts/Health Savings Account

The IRS has increased the HSA contribution limits for 2023. The annual limit on HSA contributions will be $3,850 for teammate only coverage and $7,750 for family coverage. Catch-up contributions for those ages 55 or older remains $1,000.

The maximum contribution limit for Health Flexible Spending Account for 2023 will be $2,850. The maximum contribution limit for Dependent Care FSA remains $5,000.

Dental

RSFH is transitioning from Delta Dental of Missouri to Delta Dental of Ohio. We are pleased to share that there will be three different plans from which to choose: Core, CorePlus, and Enhanced.

If you elected dental coverage in 2022, and you do not make changes during open enrollment, you will be automatically enrolled in the CorePlus plan for 2023. All teammates with dental coverage for 2023 will receive a new dental ID card in the mail from Delta Dental of Ohio. Cards issued by Delta Dental of Missouri will no longer be valid.

Have a question?

Contact the HR Benefits Team at **843-720-8400, Option 2** or by email at **HRBenefitsTeam@rsfh.com**

How to Enroll

STEP 1 CONSIDER YOUR OPTIONS

- Visit **RSFBenefits.com** and take the time to review the "What's New for 2023" page along with our medical, dental, vision and other plan options to determine the best plan for you and your family.
- Determine your contribution into your Health Savings Account (for **Alliance *Save*** participants) and/or Flexible Spending Accounts (Health and Dependent Day Care).

STEP 2 MAKE YOUR SELECTIONS

- ALL teammate usernames and passwords are reset for Open Enrollment.

  Username: Use "RSF" plus your employee number (ex. If your employee number is 103123, enter RSF103123. Do not include the first initial of your name.)

  Password: Use your date of birth in this format: the 2-digit date of your birth followed by the first 3 letters of your birth month followed by the 4-digit year of your birth (ex. 08Jun1976).
- Complete your selections from Oct. 6-27 by visiting the RSFH Benefits website at **RSFBenefits.com**. or the Benefitplace™ app.

STEP 3 CONFIRM YOUR SELECTIONS

- Print your confirmation statement from the website as proof of enrollment. No confirmation statements will be mailed to your home.
- Please note that adding dependents to the plans requires you to submit the necessary documentation prior to your enrollment deadline.

IMPORTANT

Your 2022 elections for Health Savings Accounts, Health Flexible Spending Accounts and Dependent Care Flexible Spending Accounts do NOT carry over, so you must actively enroll in these plans if you want to participate in 2023. If you do not make any changes, your 2022 elections for medical, dental, vision, disability and supplemental/dependent life insurance will carry over for 2023.

Coverage for Frequently Used Services

This is a summary. If there is a discrepancy between this summary and the plan document, the plan document controls.

BENEFITS	ALLIANCE *PRIME*		ALLIANCE *FLEX*		
	RSFH HEALTH ALLIANCE NETWORK		RSFH HEALTH ALLIANCE NETWORK		BLUECROSS NETWORK
	RSFH-OWNED	RSFH-AFFILIATE	RSFH-OWNED	RSFH-AFFILIATE	
Calendar Year Deductible	$500/individual $1,000/family		$1,000/individual $2,000/family		$2,000/individual $4,000/family
Out-of-Pocket Maximum *(includes deductible)*	$3,000/individual $6,000/family		$2,750/individual $5,500/family		$3,500/individual $7,000/family
Cross Application	Not applicable		Deductibles and Out-of-Pocket Maximums cross apply to RSFH Health Alliance Network and BlueCross Network		
Primary Care Doctor Office Visits *(PCP)*	$20 co-pay		$20 co-pay		$30 co-pay
RSFH Virtual Care - Primary Care	$15 co-pay	Not covered	$15 co-pay	Not covered	Not covered
Specialty Care Doctor Office Visits	$60 co-pay		$60 co-pay		$70 co-pay
Coinsurance Paid by You	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
PREVENTIVE CARE	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Routine Physicals	100% covered		100% covered		100% covered
Well-Child Visits	100% covered		100% covered		Pay 50% after deductible
Weight Loss	100% covered up to $600		100% covered up to $600		Pay 50% after deductible
Mammograms	100% covered (all deemed preventive)	Pay 50% after deductible	100% covered (all deemed preventive)	Pay 50% after deductible	Pay 50% after deductible
Annual Well-Woman Visit	100% covered		100% covered		100% covered
Other Gynecological Exams	$20 co-pay		$20 co-pay		$30 co-pay
Colonoscopy	100% covered (all deemed preventive)	Pay 50% after deductible	100% covered (all deemed preventive)	Pay 50% after deductible	Pay 50% after deductible
BEHAVIORAL HEALTH	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Inpatient/Outpatient	Pay 20% after deductible		Pay 20% after deductible		
RSFH Virtual Care - Therapy	$20 co-pay	Not covered	$20 co-pay	Not covered	Not covered
Office	Primary Care: $20 co-pay Specialist: $60 co-pay		Primary Care: $20 co-pay Specialist: $60 co-pay		
HOSPITAL CHARGES *(inpatient and outpatient)*	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Hospital Facility Charges	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
Physician Charges	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
URGENT AND EMERGENCY CARE	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Urgent Care	$20 co-pay	n/a	$20 co-pay	n/a	$70 co-pay
Emergency Room *(copay waived if admitted)*	$250 co-pay		$250 co-pay		$250 co-pay
Ambulance	Pay 20% after deductible		Pay 20% after deductible		Pay 20% after deductible
OUTPATIENT SERVICES	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Outpatient Routine Radiology *(x-ray)*	$50 co-pay	Pay 50% after deductible	$50 co-pay	Pay 50% after deductible	Pay 50% after deductible
Outpatient Specialty Radiology *(MRI, PET, CT)*	$100 co-pay	Pay 50% after deductible	$100 co-pay	Pay 50% after deductible	Pay 50% after deductible
Outpatient Laboratory	$20 co-pay	Pay 50% after deductible	$20 co-pay	Pay 50% after deductible	Pay 50% after deductible
Outpatient Surgery *(facility)*	Pay 20% after deductible	Pay 50% after deductible	Pay 20% after deductible	Pay 50% after deductible	Pay 50% after deductible
Outpatient Surgery *(physician/surgeon)*	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
Outpatient Dialysis	Pay 20% after deductible		Pay 20% after deductible		Pay 20% after deductible
Outpatient Chemotherapy	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
Bariatric Surgery	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
OTHER SERVICES	**RSFH HEALTH ALLIANCE NETWORK**		**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**
Therapy Services *(Physical, Speech, Occupational)* *Limited to 40 visits combined all network tiers per person per year*	$60 co-pay per condition		$60 co-pay per condition		$70 co-pay per condition
Durable Medical Equipment	Pay 20% after deductible		Pay 20% after deductible		
Spinal Manipulations *(chiropractic care, massage therapy) Limited to $1,000 maximum per member per benefit year*	Pay 50% (not subject to deductible)		Pay 50% (not subject to deductible)		
Home Health Care *(limited to 100 visits annually)*	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
Hospice	Pay 20% after deductible		Pay 20% after deductible		
Organ Transplants and Transplant Evaluations	Pay 20% after deductible		Pay 20% after deductible		
Clinical Trials	Pay 20% after deductible		Pay 20% after deductible		Pay 50% after deductible
PRESCRIPTION COVERAGE	**MEDIMPACT PHARMACY CLAIMS ADMINISTRATOR**				
Prescription Drug Deductible	Not applicable		Not applicable		
Prescription Drug Out-of-Pocket Maximum	$1,200 individual/$2,400 family		$1,200 individual/$2,400 family		
Retail Prescription Drug *(Generic/High-Cost Generic/Brand/Non-Preferred Brand)*	$10/ $20/$35/ Pay 40% ($50 min/$150 max)		$10/ $20/$35/ Pay 40% ($50 min/$150 max)		
Mail Prescription Drug *(Generic/ High-Cost Generic/Brand/Non-Preferred Brand)*	$20/ $40/$87.50/ Pay 40% ($125 min/$375 max)		$20/ $40/$87.50/ Pay 40% ($125 min/$375 max)		

*Any combination of covered individuals can meet the family deductible; there is no individual deductible.
**Any combination of covered individuals can meet the family out of pocket maximum; there is no individual out of pocket maximum.

BENEFITS	ALLIANCE *SAVE*			
	RSFH HEALTH ALLIANCE NETWORK		BLUECROSS NETWORK	OUT OF NETWORK
	RSFH-OWNED	RSFH-AFFILIATE		
Calendar Year Deductible	Individual Coverage: $1,750/individual Family Coverage*: $3,500/family		Individual Coverage: $2,500/individual Family Coverage*: $5,000/family	Individual Coverage: $5,000/individual Family Coverage*: $10,000/family
Out-of-Pocket Maximum *(includes deductible)*	Individual Coverage: $3,500/individual Family Coverage**: $7,000/family		Individual Coverage: $5,000/individual Family Coverage: $7,150/individual $10,000/family	Unlimited
Cross Application	Deductibles and Out-of-Pocket Maximums cross apply to RSFH Health Alliance Network and BlueCross Network			Not Applicable
Primary Care Doctor Office Visits *(PCP)*	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
RSFH Virtual Care - Primary Care	Pay 20% after deductible	Not covered	Not covered	Pay 50% after deductible
Specialty Care Doctor Office Visits	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Coinsurance Paid by You	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
PREVENTIVE CARE	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Routine Physicals	100% covered		100% covered	Pay 50% after deductible
Well-Child Visits	100% covered		Pay 30% after deductible	Pay 50% after deductible
Weight Loss	100% covered up to $600		Pay 30% up to $600	Pay 50% up to $600
Mammograms	100% covered (all deemed preventive)	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
Annual Well-Woman Visit	100% covered		100% covered	Pay 50% after deductible
Other Gynecological Exams	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Colonoscopy	100% covered (all deemed preventive)	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
BEHAVIORAL HEALTH	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Inpatient/Outpatient	Pay 20% after deductible			Pay 50% after deductible
RSFH Virtual Care - Therapy	Pay 20% after deductible	Not covered	Not covered	Not Applicable
Office	Pay 20% after deductible			Pay 50% after deductible
HOSPITAL CHARGES *(inpatient and outpatient)*	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Hospital Facility Charges	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Physician Charges	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
URGENT AND EMERGENCY CARE	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Urgent Care	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Emergency Room *(copay waived if admitted)*	Pay 20% after deductible		Pay 20% after deductible	Pay 20% after deductible
Ambulance	Pay 20% after deductible		Pay 20% after deductible	Pay 20% after deductible
OUTPATIENT SERVICES	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Outpatient Routine Radiology *(x-ray)*	Pay 20% after deductible	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
Outpatient Specialty Radiology *(MRI, PET, CT)*	Pay 20% after deductible	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
Outpatient Laboratory	Pay 20% after deductible	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
Outpatient Surgery *(facility)*	Pay 20% after deductible	Pay 30% after deductible	Pay 30% after deductible	Pay 50% after deductible
Outpatient Surgery *(physician/surgeon)*	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Outpatient Dialysis	Pay 20% after deductible		Pay 20% after deductible	Pay 50% after deductible
Outpatient Chemotherapy	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Bariatric Surgery	Pay 20% after deductible		Pay 30% after deductible	Not covered
OTHER SERVICES	**RSFH HEALTH ALLIANCE NETWORK**		**BLUECROSS NETWORK**	**OUT OF NETWORK**
Therapy Services *(Physical, Speech, Occupational) Limited to 40 visits combined all network tiers per person per year*	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Durable Medical Equipment	Pay 20% after deductible			Pay 50% after deductible
Spinal Manipulations *(chiropractic care, massage therapy) Limited to $1,000 maximum per member per benefit year*	Pay 50% after deductible			
Home Health Care *(limited to 100 visits annually)*	Pay 20% after deductible		Pay 30% after deductible	Pay 50% after deductible
Hospice	Pay 20% after deductible			$3,000 benefit maximum
Organ Transplants and Transplant Evaluations	Pay 20% after deductible		Pay 30% after deductible	Not covered
Clinical Trials	Pay 20% after deductible			Not covered
PRESCRIPTION COVERAGE	**MEDIMPACT PHARMACY CLAIMS ADMINISTRATOR**			
Prescription Drug Deductible	Included in Medical deductible			Not covered
Prescription Drug Out-of-Pocket Maximum	Included in Medical Out-of-Pocket Maximum			Not covered
Retail Prescription Drug *(Generic/ High-Cost Generic/Brand/Non-Preferred Brand)*	Pay 30% after deductible			Not covered
Mail Prescription Drug *(Generic/ High-Cost Generic/ Brand/Non-Preferred Brand)*	Pay 30% after deductible			Not covered

2023 Medical Plan Rates

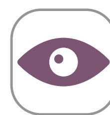
		QUALIFIED* (BI-WEEKLY)	NOT QUALIFIED (BI-WEEKLY)
ALLIANCE *PRIME*			
Full Time	TM Only	$66.88	$107.26
	TM+Spouse	$194.05	$234.43
	TM+Children	$105.15	$145.53
	Family	$223.98	$264.36
ALLIANCE *FLEX*			
Full Time	TM Only	$114.10	$154.49
	TM+Spouse	$331.16	$371.54
	TM+Children	$249.74	$290.12
	Family	$466.65	$507.02
ALLIANCE *SAVE*			
Full Time	TM Only	$9.60	$47.67
	TM+Spouse	$109.48	$149.87
	TM+Children	$75.77	$116.16
	Family	$162.05	$202.43

		QUALIFIED* (BI-WEEKLY)	NOT QUALIFIED (BI-WEEKLY)
ALLIANCE *PRIME*			
Part Time	TM Only	$141.51	$181.89
	TM+Spouse	$406.82	$447.21
	TM+Children	$254.91	$295.29
	Family	$542.98	$583.36
ALLIANCE *FLEX*			
Part Time	TM Only	$241.51	$281.90
	TM+Spouse	$694.28	$734.66
	TM+Children	$526.17	$566.55
	Family	$970.67	$1,011.05
ALLIANCE *SAVE*			
Part Time	TM Only	$9.60	$47.67
	TM+Spouse	$229.84	$270.22
	TM+Children	$165.58	$205.98
	Family	$354.13	$394.51

Your 2023 Dental Plan Biweekly Contributions

FULL-TIME	CORE PLAN	COREPLUS PLAN	ENHANCED PLAN
TM Only	$6.41	$11.43	$13.75
TM + Spouse	$13.46	$24.00	$28.88
TM + Child(ren)	$16.66	$29.56	$35.55
Family	$25.60	$45.54	$54.73

PART-TIME	CORE PLAN	COREPLUS PLAN	ENHANCED PLAN
TM Only	$7.21	$12.23	$14.55
TM + Spouse	$15.14	$25.69	$30.56
TM + Child(ren)	$18.74	$31.64	$37.63
Family	$28.80	$48.74	$57.93



Your 2023 Vision Plan Biweekly Contributions

FULL-TIME AND PART-TIME	
Teammate	$3.69
Teammate + Spouse	$7.43
Teammate + Child(ren)	$8.11
Family	$11.89

**Teammates with a hire date, status change, or life event with an effective date from January 1, 2023, through December 31, 2023, will default to the Qualified status for enrollment in the 2023 and 2024 medical plans*

ROPER ST. FRANCIS HEALTHCARE