ST. JOSEPH HEALTH SYSTEM

Covenant Health System

2012 Benefits Overview Guide

St. Joseph Health System - Humboldt County

Benefits *for a* Better Way *of* Life

Benefits *for a* Better Way *of* Life:

A Program that Meets Your Health and Welfare Benefits Needs

At St. Joseph and Redwood Memorial Hospital we are proud to offer you a comprehensive and competitive variety of benefits and programs to enhance and enrich your way of life.

We recognize that no single benefit plan is right for everyone, that is why SJE/RMH allows you to choose from a variety of benefit options. Open enrollment is your opportunity to review the information on your personalized enrollment statement, consider the benefit options available, and select those most appropriate for you and your family.

If this is your first opportunity to enroll as a new hire or because you are newly benefit eligible due to changes in employment classification, complete your enrollment by the deadline indicated in your personalized Benefits Enrollment Guide. You will be eligible for benefits the first of the month after 30 days from your date of hire or on the benefits effective date indicated in your Benefits Enrollment Guide.

Please keep in mind, the benefits elections you make will be in effect through December 31, 2012, unless you have a qualified change in status during the year.

SJE/RMH is committed to your health and welfare and providing these benefits to you and your family. We want you to be healthy and well cared for in the same way you care for our patients, families and the communities we serve. Don't miss out on this great opportunity to enroll in these valuable benefits!

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DIGNITY

We respect each person as an inherently valuable member of the human community and as a unique expression of life.

SERVICE

We bring together people who recognize that every interaction is a unique opportunity to serve one another, the community, and society.

EXCELLENCE

We foster personal and professional development, accountability, innovation, teamwork, and commitment to quality.

JUSTICE

We advocate for systems and structures that are attuned to the needs of the vulnerable and disadvantaged and that promote a sense of community among all persons.

The *Benefits for a Better Way of Life* program is an essential part of your total compensation as an employee of St. Joseph Health System. Your total compensation includes your pay, benefits, retirement, and recognition programs.

Our *Benefits for a Better Way of Life* philosophy is designed to ensure that these programs reflect St. Joseph Health System's commitment to values and uphold our mission, values, vision, and strategic goals.

Our values continue a tradition of excellence and a dedication to help heal all we touch.

Enrolling *in* SJE/RMH Benefits *for* 2012

St. Joseph and Redwood Memorial Hospital offers a flexible benefits plan. Flexible benefits allow you to choose among a range of benefits and levels of coverage, enabling you to create your own personalized benefit package.

You have the choice of coverage levels in many benefit areas. Coverage is effective the first day of the month following 30 days of employment for benefits-eligible employees. The cost of an option depends on the type of coverage it offers.

Benefits Eligibility

All regular full- or part-time employees are eligible to enroll for health care benefits. Full-time and part-time employees are defined as follows:

Full-Time	72-80 hours per pay period
Part-Time	40-71 hours per pay period

Employees are eligible for benefits on the first of the month following 30 days of employment.

If You Are Married to Another SJHS Employee

If you and your spouse are both employees of SJHS, it is important to remember that SJHS does not permit "double coverage," that is, you may not elect coverage as both an employee and a dependent.

Only you or your spouse can elect coverage for your eligible dependent children. Also, dependent children may not elect coverage as an employee if they are covered by their parent as a dependent.

If You Work at More than One SJHS Location

If you work at more than one SJHS facility you will only be able to enroll for benefits at your primary location.

If You Do Not Enroll

Open Enrollment

If you do not make changes during the Open Enrollment period, your current benefit elections will automatically carry over to 2012 – with the exception of the Flexible Spending Accounts which require re-enrollment each year. Any election to cover a dependent will also remain as long as eligibility requirements are met.

New Hire or newly Eligible Enrollment

If you're enrolling for the first time and you don't enroll by the specified deadline, your benefits will default as indicated below. Keep in mind, with default coverage your dependents will not be covered.

- **Medical — No coverage**
- **Dental — No coverage**
- **Vision — No coverage**
- **Employee Life — Basic Coverage**
- **Dependent Life — Spouse—No Coverage**
- **Dependent Life — Child(ren)—No Coverage**
- **AD&D — Basic Coverage**
- **LTD — 50% of base pay/180-day waiting period**
- **Group Legal Plan — No Coverage**
- **Flexible Spending Accounts — No Participation**

The Pre-Tax Advantage

A significant advantage of flex programs is that the IRS allows the amount you contribute for most plans to be deducted from your taxable wages (permitted under Section 125 of the Internal Revenue Code). Pre-tax contributions actually lower your taxable income, which means you pay fewer federal and state income taxes.

Federal law dictates which benefits are paid for with pre-tax contributions and which are paid with after-tax contributions. Plans paid with after-tax dollars are: Dependent Life, Supplemental Life, Long-Term Disability Insurance and Group Legal as well as coverage for a Legally Domiciled Member.

Dependent Eligibility

Dependent Eligibility

The following dependents are eligible for coverage (Social Security numbers will need to be provided for all enrolled dependents):

- **Your legal spouse.**
- **Your children under age 26, regardless of student status.**
- **Your unmarried children age 26 and older who are mentally or physically disabled and unable to support themselves financially (physician-certified documentation must be provided) if enrolled prior to age 26.**
- **A Registered Domestic Partner (RDP) – an adult who has filed, along with you, a Declaration of Domestic Partnership with the California Secretary of State and at the time of filing, all of the following requirements have been met:**
  - **Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity**
  - **The two persons are not related by blood in a way that would prevent them from being married to each other in California**
  - **Both persons are at least 18 years of age**
  - **Both persons are capable of consenting to the domestic partnership**
- **A Legally Domiciled Member (LDM) – an individual (who is not otherwise eligible for benefits as your dependent) who, on a long-term basis, shares your principal place of residence and is a member of your household.**
  - **You may only enroll an LDM provided you are not already covering a spouse or RDP under the same coverage. Only one adult LDM may be enrolled. You may also enroll your LDM's unmarried children, as long as they meet all qualifications of dependent children.**
  - **To enroll a new LDM, you must submit a Declaration of LDM Status and enrollment form. A dependent verification kit will be mailed to you and will include the necessary paperwork for you to complete. Please contact the Benefit Service Center if you have questions regarding mid-year LDM enrollment changes.**
  - **In order to continue covering an existing LDM on your benefits for 2012, you must recertify that they meet the eligibility definition under the program each year. If you wish to continue covering your Legally Domiciled Member's coverage for 2012, you must provide proof of their relationship with you to the Benefit Service Center by midnight Central Standard Time on December 31, 2011.**
  - **You cannot enroll any child or adult who is not a Legally Domiciled Member of your household (see page 25 for definition). You will be required to furnish proof of a dependent's status and relationship before a dependent's coverage can begin.**

Dependents, including LDM's, may be enrolled online through the Benefit Service Center.

Family Coverage Categories

For medical, dental, and vision benefits, you may choose from four coverage categories:

- **Employee Only**
- **Employee and Child(ren)**
- **Employee and Adult**
- **Employee and Family**

You may choose different coverage categories for different plans. For example, you may choose Employee Only for medical and Employee and Family for dental.

Dependent Verification

In order to cover dependents you have recently enrolled, you must provide certain documentation to verify their eligibility in the SJE/RMH medical, dental and/or vision plans. You will be provided a Dependent Verification Kit which will explain the documentation that is acceptable for proving dependent eligibility. The required information must be returned to the Benefit Service Center ***by December 31, 2011****. If you are adding a dependent during the year as a result of an IRS qualified status change, return the paperwork* ***no later than 30 days after the date you enrolled your dependents.*** *From time to time, SJE/RMH will conduct a Dependent Eligibility Audit, using an outside consulting firm, to determine whether dependents currently enrolled in benefits continue to be eligible.*

Qualified Change in Status

Generally, the levels of coverage you select remain in effect for the entire plan year, which runs from January 1, through December 31, 2012. However, there are exceptions to this rule when you experience a "qualified change in status" such as:

- **Marriage**
- **Divorce or legal separation**
- **Birth, adoption, or other legally recognized assignment of guardianship**
- **Death of your spouse or a dependent child**
- **A dependent becomes ineligible for coverage**
- **Your spouse gains or loses coverage at his or her job, or there is a significant change in your spouse's coverage**
- **You switch between full-time and part-time employment**

A qualified change in status may allow you to drop or add a dependent. However, any change you make must be consistent with the change in your family circumstances.

If you experience a qualified change in status, you must contact the Benefit Service Center within 31 days of the change or event. Otherwise, you will not have the opportunity to make changes until the next Open Enrollment period. All required paperwork must be returned to the Benefit Service Center within 30 days of the date you reported the change.

Benefit Service Center

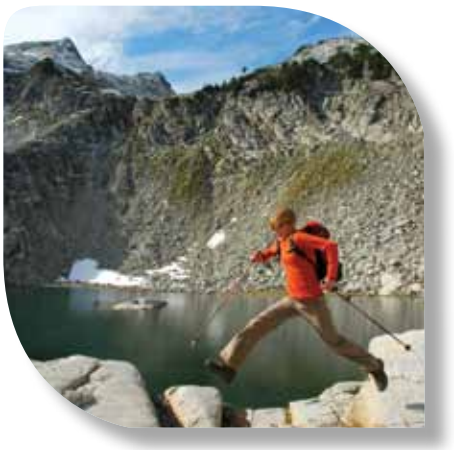
We're here to help!

We understand that there are a lot of considerations and many decisions to make when selecting your benefits coverage. We encourage you to review your benefits enrollment materials carefully as they contain information you need to make the best decision about your benefits.

This Benefits Overview Guide provides a summary of the St. Joseph and Redwood Memorial Hospital sponsored benefits and highlights considerations when making your benefits enrollment decisions. When it's time to make your enrollment elections, you will receive a Benefits Enrollment Letter which includes steps to selecting your benefits. In addition, the Benefit Service Center is a great resource to obtain answers to your questions – either online or by speaking with a professional, skilled benefits representative!

24 hours, 7 days a week assistance!

You have access anytime to the Benefit Service Center Web site which has a wealth of benefits information. If you have additional questions and want to speak with a benefits representative, you may call 800-306-4363 for assistance 24 hours a day, 7 days a week, excluding major national holidays.



How do I enroll in my benefits?

You have two options to enroll in your benefits:

Online: To access the Benefit Service Center Web site go to *CAREnet* at www.myCAREnet.org and select *MyHR* under the *HR & Benefits* tab. Login to *MyHR* using your PeopleSoft user ID and password and click the *Benefit Service Center* link.*

Access the Benefit Service Center Web site to enroll in benefits coverage, review health care plan information, access your Flexible Spending Account balance, obtain insurance carrier contact information, and get answers to other benefit questions.

By Phone: 800-306-4363

Call the Benefit Service Center, 24 hours a day, 7 days a week, to speak with a benefits representative. In addition to assisting with your enrollment, benefit representatives can answer your benefit plan questions, assist with claim inquiries, update your benefit elections if you experience a qualified status change, discuss your beneficiary designation and connect you to insurance providers.

**If you are unable to access CAREnet because you have an unsupported internet browser, you may access the MyHR Web site directly at https://myhr.stjoe.org.*

If you need assistance with your CAREnet or PeopleSoft User ID & Password, please call the IT HelpDesk at 877-552-7547.

Benefits Enrollment is designed to be easy and convenient. The Benefit Service Center allows you to handle your own benefits enrollment 24 hours a day, 7 days a week – enabling you to make your benefit elections whenever and wherever it is most convenient for you.

YOU MUST ENROLL BY THE DEADLINE LISTED IN YOUR BENEFITS ENROLLMENT GUIDE OR YOU WILL BE GIVEN THE DESIGNATED DEFAULT COVERAGE LEVEL (SEE PAGE 3 FOR DETAILS).

Your Medical Option — Humboldt County PPO Plan

YOU MAY CHOOSE ONE OF TWO OPTIONS:

- **Humboldt County PPO Plan**
- **Waive coverage***

** To waive medical coverage, you must provide proof of other coverage.*

Preferred Provider Option (PPO) Plan

The PPO Plan covers a wide range of services. You may choose to receive care from any provider, but when you use a network provider your out-of-pocket costs will be lower and you do not have to file claims.

PPO network providers belong to the Humboldt-Del Norte IPA, Anthem Blue Cross (within California) and Multi Plan (outside of California) networks. Please note that many services are covered at 100% when received at St. Joseph Hospital - Eureka (SJE) or Redwood Memorial Hospital (RMH), including:

- **Laboratory and X-ray**
- **Hospital Inpatient and Outpatient Services**
- **Physical, Occupational and Speech Therapy**
- **Inpatient Mental Health Services**

Mental Health Benefits

Mental health benefits are generally covered under the plan as any other medical expense.

Counseling and referrals for a range of personal and family issues are available to all employees and their families through the Employee Assistance Program (EAP). EAP services are provided by the Humboldt-Del Norte Foundation for Medical Care and cover three face-to-face sessions with a network counselor per occurrence at no cost to you. Contact them at 707-443-1303.

Health Plan Prior Authorization Requirements

You must contact Delta Health Systems at 866-457-0528 BEFORE:

- **Admissions to a hospital or skilled nursing facility (within 24 hours or on the next business day after an emergency admission); prior authorization is not needed for mastectomy surgery**
- **Pregnancy confinements expected to last over 48 hours (96 hours for a cesarean section delivery)**
- **Non-emergency out-patient hospital services, excluding lab and plain x-ray**
- **Facility-based treatment for mental health conditions or substance abuse; authorization is for the place of service, not medical necessity**
- **Certain diagnostic procedures: CT, MRI, PET scan or Dexa scan, regardless of where they are to be performed**
- **Durable medical equipment and prosthetics with a value of $750 or more**
- **Acupuncture, chiropractic care and speech and physical/occupational therapy after a combined total of more than 10 visits in a calendar year**
- **Home health care, each course of infusion therapy in an outpatient setting, biopharmaceuticals**
- **Organ and tissue transplants, peripheral stem cell replacement and similar procedures**

Prior authorization is not a guarantee of coverage, as benefits will depend on eligibility and the plan's limitations and exclusions.

Making Your Medical Coverage Decision

To decide which medical coverage you want, it may be helpful to ask yourself these questions:

- **Do you expect to have high medical bills this year?**
- **Who else in your family, besides yourself, will need health care coverage next year?**
- **Do you have medical coverage from another source that better suits your needs?**

Your Medical Option *at a* Glance

HUMBOLDT COUNTY PPO PLAN

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE	$150 per person $300 per family waived if SJE/RMH facility utilized	$400 per person $800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$1,000 per person $3,000 per family	$2,000 per person $6,000 per family
COPAYMENTS		
Office Visits	$20 copayment	50% after deductible
Specialist	$20 copayment	50% after deductible
Hospitalization	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible	50% after deductible
Emergency Room Visits	$50	$50
Urgent Care	$25	$25
HOSPITAL SERVICES		
Inpatient	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible.	50% after deductible
Outpatient Surgery	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible	50% after deductible
OUTPATIENT REHABILITATION SERVICES		
Physical Therapy	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible*	50% coinsurance after deductible*
Occupational Therapy	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible*	50% coinsurance after deductible*
Speech Therapy	$0 copayment if SJE/RMH facility used; otherwise 20% after deductible*	50% coinsurance after deductible*

**Limited to 10 visits combined with all therapies, including chiropractic unless pre authorized for additional visits.*

Prescription Drug Coverage — Express Scripts, Inc. (ESI)

Coverage for prescription drugs is available for all employees and eligible dependents who are enrolled in the Humboldt County PPO Plan.

The program, administered by Express Scripts, offers discounts on your prescription drug purchases through a network of pharmacies. When you go to a network pharmacy, simply present your Express Scripts card and pay your portion of the cost according to the following schedule:

	Non-Maintenance Drug Filled at Local Pharmacy	Maintenance Drug Filled at Local Pharmacy	Filled through Home Delivery*
Generic Drugs	$5	$10 / 30-day supply	$10 / 90-day supply
Preferred Brand	$25	$40 / 30-day supply	$50 / 90-day supply
Non-Preferred Brand	$40	$55 / 30-day supply	$80 / 90 day supply

**Forms for mail order prescriptions are available by contacting Express Scripts. Please return the completed forms, along with your doctor's prescription, directly to Express Scripts for processing.*

For a list of covered drugs, see the Express Scripts Prescription Drug Formulary, available online at www.express-scripts.com (You will first need to register on ESI's Web site to view the Formulary Listing).

Home Delivery

Your prescription drug coverage for maintenance medications is made up of a mail order format. This program can help you save time and stay safe by getting these medications through Home Delivery. Maintenance drugs are prescription drugs taken over a period of time for chronic or ongoing conditions, such as arthritis, high blood pressure or asthma. In order to make your transition an easy one, you can fill your first two months of maintenance medications at your local pharmacy. After that you will be able to receive a discount on your co-payment by ordering these prescriptions through Home Delivery from the Express Scripts (ESI) Pharmacy. If you continue to fill your maintenance prescription at a retail pharmacy, your co-payment will increase.

Example 1: Jane is currently on two maintenance medications. She can fill the two prescriptions at her local pharmacy in January and February. Beginning in March, Jane will begin paying a higher co-payment unless she chooses to receive her medications through the Home Delivery Program.

Example 2: Currently John is not taking any maintenance medications. In February, John's PCP prescribes him a maintenance medication. John can fill his prescription up to two times (60 days of medication) at his local pharmacy. Beginning in April, John will begin paying a higher co-payment unless he chooses to start receiving his medication through the Home Delivery Program.

It's Easy to Get Started!

- **Go to www.StartHomeDelivery.com**
- **Let ESI do the work for you by calling 888-202-4560 available 7:00am to 5:30pm Monday through Friday.**

ESI will contact your physician for you and get a 90-day prescription, all you have to do is go to their web site or call the toll-free number. (Remember to have a 30-day supply of your medication(s) on hand when you first order your prescriptions.)

Prescription Drug Coverage — Express Scripts, Inc. (ESI)

Step Therapy

Step Therapy is a program with an approach to getting patients the prescription drugs they need, with safety, cost and, most importantly, their health in mind. The program makes prescription drugs more affordable for most members and helps us control the rising cost of medication so that we can continue to provide prescription drug coverage.

How it Works:

Certain drug classes are organized in a set of "steps" with generic drugs being the first step, with drugs that have generics available, and brand name drugs being the second and third steps. Step-Therapy is identified as one of the least disruptive programs and has been in the marketplace for about 8-10 years.

Step 1: Generic drugs should be tried first as they can provide the same health benefits at a lower cost. If a generic drug has been used in the previous 130 days, the patient is automatically moved to Step 2.

- **Although generics have a different name, color and/or shape, they have exactly the same chemical makeup and the same effect in the body as their original brand-name counterparts. From a safety standpoint, generics also have an advantage in that they have been utilized by more patients for more years and any side effects should have been identified.**

Step 2-3: Brand-name drugs like those that are advertised on television. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Brand-name drugs typically cost more than generic drugs.

Process:

- **If a patient presents a prescription for a brand-name drug (in a step therapy class) at the pharmacy, the pharmacist will see a message on their computer indicating that it is not a Step 1 drug.**
- **The pharmacist, if familiar with the member and health conditions, can call ESI, explain the medical history and request an instant override and dispense the drug; OR,**
- **The pharmacist can call the prescribing physician and request the prescription be changed to generic. If the physician approves the generic over the phone, the pharmacist can accept the telephonic approval and dispense the drug.**
- **If the physician does not approve Step 1 drug, the physician can call ESI for an override. Once override is approved, the drug can be dispensed.**
- **If a prescription is presented at the pharmacy and is not changed to generic or overridden or dispensed within 48 hours, ESI will mail a letter to the physician and the member regarding the outstanding prescription.**

Prescription Drug Coverage — Express Scripts, Inc. (ESI)

Prior Authorization Process

Certain drugs will require additional review by Express Scripts (ESI) before the prescription will be dispensed. This is to ensure that drug therapy is clinically appropriate and cost-effective. Approved Prior Authorizations are good for one year, after which they will be reviewed again for appropriateness.

The process is as follows:

- **You receive a prescription from your physician and go to the pharmacy.**
- **If you have an active prior authorization, the prescription is processed.**
- **If you do not have an active prior authorization, the pharmacist will tell you and either;**
  - **call the ESI prior authorization department directly (if the pharmacist has sufficient data), or**
  - **call your prescribing physician and instruct him to contact ESI, or**
  - **tell you to contact your prescribing physician directly.**
- **Your pharmacist or physician will call ESI. Once a call is placed to ESI, ESI will determine whether clinical criteria (based on FDA standards for that medication) are met, and if so, issue an override and determine the claim as "payable."**
- **If clinical criteria are not met, the claim will be denied and you and your physician will be notified for alternative clinical/prescriptive options.**

The process takes anywhere from immediate processing up to approximately 48 hours (depending on physician timeliness and method in which the review is submitted).

Medicare Part D – Medicare participants have access to a voluntary prescription drug benefit known as Medicare Part D. If you are an active SJE/RMH employee who is eligible for this benefit, you may be wondering if you should enroll. In a word, no. Because you already receive prescription drug benefits from the Health System, there is no need for you to enroll in Medicare Part D. The coverage under our plan is as good as – or better than – the coverage provided by Medicare Part D.

Specialty Pharmacy - CuraScript

A specialty pharmacy provides injectable, oral and infused medications that are complex, costly and may require special storage and handling.

Express Scripts is dedicated to serving the needs of patients using specialty medication — CuraScript is the Express Scripts Specialty Pharmacy designed to meet the needs of employees and dependents with specialty pharmacy needs.

If you or one of your dependents takes a specialty medication, you will need to go through CuraScript to obtain your medication after one time at the local pharmacy. CuraScript will deliver your medication to your home, your doctor's office or any approved location. Additionally, CuraScript will provide you with a patient care coordinator, a professional caregiver who will be sure you receive the best treatment, remind you to refill a prescription and schedule delivery of your medication.

As of January 1, 2012, prescriptions for certain specialty drugs will also be tied to the Step Therapy Program.

To get started, you can contact CuraScript at 1-866-848-9870 or online at www.express-scripts.com. If you are on one of these specialty medications, you will receive communications from CuraScript directly.

Benefits available through CuraScript include:

- **Access to specialty experts dedicated to serving members with a higher level of personal care.**
- **Care management programs to help ensure members are taking medication correctly and to provide the support they need to manage their condition.**
- **Patient care coordinators who will provide comprehensive clinical management service.**
- **Supplies for administering medications (syringes, needles, alcohol swabs).**
- **Access to a pharmacist 24 hours a day/ 7 days a week.**
- **Specialty medications delivered to the home, doctor's office or any approved location via overnight delivery.**

Choose Well Program

At St. Joseph Health System (SJHS), our vision is to bring people together to provide compassionate care, promote health improvement and create healthy communities, which also includes our internal community. It is our commitment to create a workplace where each person is an inherently valuable member of the St. Joseph Health System family and your health and well-being is important to us. *Choose Well* is our health system's wellness program that is designed to provide you with resources that will help you reach your wellness potential. Our transformational statement calls us to embrace both illness and a wellness model and to achieve that we have invested in our mission outcome of building the healthiest communities. *Choose Well* provides us with a unique opportunity to align with our external efforts by implementing this multi-dimensional program designed specifically for our health system.

Choose Well provides you access to a variety of outstanding health and well-being support, all designed to help you become your personal best. Whether you want to lose weight, eat healthier, get in shape, or just feel better, *Choose Well* makes it all possible.

Participation in the *Choose Well* program includes:

- **A biometric screening with a health professional**
- **A confidential Well Being Assessment questionnaire that is used to assess your overall health**
- **A web-based plan for well-being, personalized to help you reach your healthy best**
- **Online Personal Coaching: Confidential, web-based access to health professionals**
- **Phone Personal Health Coaching (for those who qualify)**
- **Support if you are currently living with a health condition (for those who qualify)**
- **Online fitness, nutrition and stress management plans that promote healthy behaviors**
- **Resources for quitting tobacco**
- **A walking fitness and activity program through Virgin HealthMiles**
- **And rewards and incentives for engaging in healthy activities**

If you do choose to participate, you have an opportunity through Virgin HealthMiles to earn up to $200 per year in HealthCash redeemable for dollars or gift cards. You can earn this $200 incentive by completing the various activities ($25 for completing the well-being assessment, $50 for completing a biometric screening, $25 for reaching level 2, $25 for reaching level 3, $25 for reaching level 4, and $50 for reaching level 5). To enroll in this program, visit **www.virginhealthmiles.com/stjosephhealth**.

To access the *Choose Well* program web site for additional information, go to *CAREnet* and select *MyHR* under the *HR & Benefits* tab. Login to *MyHR* using your Peoplesoft user ID and password and click the *Choose Well* link. If you have any questions on the *Choose Well* program, please visit the *Choose Well* Web site or contact Healthways at **877-393-0478** or your local ministry Wellness Coordinator.

To ensure your privacy, St. Joseph Health System has partnered with Healthways, Quest Diagnostics, and Virgin HealthMiles and your personal health information will be protected. We will never see any of your information related to this program. It's confidential, voluntary, and offered at no cost to you.

Your Dental Options — Delta Dental

YOU MAY CHOOSE ONE OF TWO OPTIONS:

- **Delta Dental DPO**
- **Waive Coverage**

Delta Dental DPO

Delta Dental offers you the flexibility to choose any dentist you wish when you need dental care. It is to your advantage to use a Delta Preferred Option (DPO) Dentist, since Delta has negotiated lower fees with these dentists. A directory of Delta Dental DPO providers is available on Delta Dental's Web site at www.deltadentalca.org as well as the Benefit Service Center Web site.

Making Your Dental Plan Decision

To decide which dental plan you want, it may be helpful to ask yourself these questions:

- **Do you visit a dentist for regular cleanings and maintenance?**
- **What kind of dental expenses will you have next year?**
- **Do you expect to have certain dental procedures performed?**
- **Do you have dependents who will require orthodontia services, such as braces?**
- **Is your current dentist in the Delta Preferred Option network?**
- **If you're in the middle of orthodontic treatment and are considering a change in coverage for 2012, see your orthodontist for information about the cost of continuing treatment. Delta participants who are switching to Delta Dental should complete a Continuous Orthodontic Coverage Form, available from Delta.**

Your Dental Options — Delta Dental

Comparing Your Dental Plan Options

	Delta Dental DPO *	
	Delta Preferred Provider	Delta Premier Provider** and Other Non-Delta Providers
Care Provider	Delta Preferred Option (DPO) Dentist	Any Licensed Provider
Annual Deductible	$25 per person $50 family maximum	$50 per person $100 family maximum
WHAT YOU PAY		
Diagnostic/Preventive regular exams, X-rays, and cleanings	$0	20% after deductible
Basic/Routine Services fillings, extractions, endodontics, and periodontics	15% after deductible	20% of pre-approved fee or UCR after deductible
Major Services bridges, crowns, dentures, oral surgery, and dental implants	50% after deductible	50% of pre-approved fee or UCR after deductible**
Orthodontia braces for children and adults	50% after deductible	50% of pre-approved UCR after deductible
Lifetime Orthodontia Maximum Benefits	$1,000 lifetime maximum per person	$1,000 lifetime maximum per person
Annual Maximum Benefits	$1,200 per person	$1,200 per person

UCR: Usual, Customary, and Reasonable

** Pre-determination recommended for dental work in which the expected cost of the plan of treatment is greater than $300. This will help you plan for the expense.*

*** If you go to a dentist who is a Delta Premier Provider, but not a Delta Preferred Provider, your benefits will be based on the dentist's pre-approved fees.*

Your Vision Options — VSP Vision Care (VSP)

VSP Vision Care (VSP)

With VSP, you have the flexibility to receive vision care from any provider or provider associated with VSP. Your benefits are higher in the VSP network. The VSP network of eligible physicians is changing to the Choice Network for 2012. This network change should not have any impact on the physicians available to you. Please go to www.VSP.com to locate your current physician or to find a physician under the Choice Network.

The key features of your vision option are:

Coverage with VSP Doctors and Affiliate Providers*

Out-of-pocket expenses limited to:

Exam $20

Materials $20

Exam covered in full ..... every 12 months

**Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.*

Prescription Glasses

Lenses covered in full ..... every 12 months

- Single vision, lined bifocal, lined trifocal lenses, and polycarbonate lenses covered in full..

Frame ..... every 24 months**

- Frame of your choice covered up to $150.
- Plus, 20% off any out-of-pocket costs.

***Frame covered every 12 months for dependent children up to age 16*

—OR—

Contact Lens Care ..... every 12 months

When you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained.

Vision Care Services from Other Providers

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP Preferred Provider. If you decide not to see a VSP doctor, copayments still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. Visit vsp.com for details, if you plan to see a provider other than a VSP doctor, or call VSP at 800-877-7195.

Out-of-Network Reimbursement Amounts:

Exam ..... Up to $50

Lenses:

Single Vision ..... Up to $50

Lined Bifocal ..... Up to $75

Lined Trifocal ..... Up to $100

Frame ..... Up to $70

Contacts ..... Up to $105

Extra Discounts and Savings

Laser Vision Correction Discounts

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.

Prescription Glasses and Sunglasses

- Average 20-25% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
- 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam.

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Your Employee Life Options — MetLife, Inc.

Employee Life Insurance provides your beneficiary with a benefit in the event of your death. There are two types of coverage:

- **Basic (provided by SJE/RMH)**
- **Supplemental (voluntary election paid by you)**

Basic coverage is equal to your annual base pay (between a minimum of $30,000 and a maximum of $50,000), rounded up to the next highest thousand dollars. Basic coverage will automatically be reduced by 65% on the first of the year following reaching age 65, and again at age 80 by 75%.

Your supplemental life deductions are made from your pay on a post-tax basis.

Supplemental coverage is offered in the flat dollar amounts shown below.

Basic	Supplemental
1 x pay up to $50,000 ($30,000 minimum)	$25,000 $50,000 $75,000 $100,000 $150,000 $200,000 $250,000 $300,000 $400,000 $500,000 $750,000 $1,000,000

Evidence of Insurability (EOI)

If you already have supplemental coverage, you may increase your supplemental coverage by one level each year up to and including $250,000 without being required to provide EOI. EOI is required for levels above $250,000.

If this is your first SJE/RMH benefits enrollment, you may elect supplemental coverage up to $250,000 without providing EOI. To elect coverage of greater than $250,000, you must provide EOI.

Finally, if this is not your first enrollment, but the first time you are electing supplemental coverage, you must provide EOI for any level of coverage greater than $25,000.

If you make an election that requires EOI, you will receive the required forms in the mail. This form must be submitted to MetLife no later than 31 days following the close of Open Enrollment or, for new hires, the date you make your election. Your elected coverage amount, up to what requires EOI, will be accepted and the remaining amount subject to EOI will be pended until approved from MetLife.

Standard Will Preparation

Standard Will Preparation is provided free of charge as part of your **Supplemental Life benefit,** through Hyatt Legal Plan, Inc. (a MetLife Company).

Your Beneficiary Designation

You may designate your beneficiary online or by calling the Benefit Service Center. Your beneficiary is a person, organization, trust or estate that you name to receive benefits in the event of your death. Your beneficiary designation may be updated at any time.

Making Your Employee Life Decision

To decide how much coverage you want, it may be helpful to ask yourself these questions:

- **Do you have other forms of life insurance?**
- **Are you married? Do you have children or other dependents to provide for?**
- **How would your family survive if you died?**

Your Dependent Life Options — MetLife, Inc.

YOU HAVE THE OPTION OF INSURING:

- **Your spouse/registered domestic partner and/or**
- **Your child(ren)**

To elect Dependent Life Insurance for either your spouse or child(ren), you must elect supplemental life coverage for yourself. The amount of coverage you elect for your spouse may not exceed the amount of coverage you have elected for supplemental life.

Spouse Options*	Children Options
• Waive Coverage • $7,500 • $15,000 • $25,000 • $50,000 • $75,000 • $100,000 • $150,000 • $200,000 • $250,000	• Waive Coverage • $2,500 • $5,000 • $7,500 • $10,000

**You may purchase Dependent Life Insurance for a domestic partner if you have registered your partnership with the State of California. You must complete a MetLife Domestic Partner Declaration form for coverage to become effective.*

Evidence of Insurability

You must provide Evidence of Insurability (EOI) to:

- **Elect any Dependent Spouse Life coverage amount for your spouse or registered domestic partner greater than $25,000 if this is your first SJE/RMH benefits enrollment.**
- **Elect any Dependent Spouse Life coverage amount for your spouse or registered domestic partner if this is not your first SJE/RMH benefits enrollment, but the first time you are electing dependent coverage.**
- **Increase any Dependent Spouse Life coverage amount for your spouse or registered domestic partner.**

Evidence of Insurability is not required for dependent children.

If you make an election that requires EOI, you will receive the required forms in the mail. The form must be submitted to MetLife no later than 31 days following the close of Open Enrollment or, for new hires, the date you make your election. Your elected coverage amount, up to what requires EOI, will be accepted and the remaining amount subject to EOI will be pended until approved from MetLife.

Age Limits

Your children are no longer eligible once they reach age 26. There is no age limit for your spouse or your registered domestic partner.

Adding a New Dependent

If you want to add a new dependent, you must do so within 31 days of his or her eligibility or during Open Enrollment.

Coverage for your dependents cannot be more than 50% of your Employee Life Insurance coverage. For example, if your coverage is $50,000, you may elect up to $25,000 for your spouse and up to the maximum $10,000 option for your child(ren).

Making Your Dependent Life Insurance Decision

To decide whether to buy Dependent Life Insurance, it may be helpful to ask yourself these questions:

- **Do you have children or other dependents?**
- **Are your children covered by any other life insurance policy?**
- **Does your spouse have his or her own life insurance policy?**
- **How would your family survive financially if your spouse died?**
- **Have any of your dependents passed the age limit?**

Your Accidental Death & Dismemberment (AD&D) Options — MetLife, Inc.

AD&D Insurance provides your family with additional financial security if you die or lose a limb or sight due to an accident. There are two types of coverage:

- **Basic (provided by SJE/RMH)**
- **Supplemental (same coverage level as election for Supplemental Life Insurance)**

Basic coverage is paid for by SJE/RMH and is equal to your annual base pay (between a minimum of $30,000 and a maximum of $50,000), rounded up to the next highest thousand dollars. Supplemental coverage is offered in the flat dollar amounts shown below. If you elect Supplemental Life Insurance coverage, you will automatically be enrolled in Supplemental AD&D at the same coverage level. No additional election is required.

Basic	Supplemental
1 x pay up to $50,000 ($30,000 minimum)	$25,000 $50,000 $75,000 $100,000 $150,000 $200,000 $250,000 $300,000 $400,000 $500,000 $750,000 $1,000,000

Your Beneficiary Designation

Be sure to name the person you would like to receive your AD&D benefits in the event of your death. You can name your life insurance beneficiary or someone else. You are the beneficiary for AD&D benefits paid out due to an accidental injury.

You may designate your beneficiary online or by calling the Benefit Service Center. Your beneficiary designation may be updated at any time.

Your Long-Term Disability (LTD) Options — MetLife, Inc.

YOUR OPTIONS ARE:

- **50% of base pay/180-day waiting period (basic coverage provided by SJE/RMH)**
- **60% of base pay/90-day waiting period (buy-up optional coverage)**

LTD provides a percentage of your base pay as monthly income if you become totally disabled by illness or injury and can no longer work. You must satisfy the waiting period before benefits begin.

The LTD plan is designed to work with benefits from other sources to keep your disability income at the percentage of base pay you elect. Benefits paid from the plan are reduced by other sources of employer and government-sponsored disability income for which you qualify, such as state disability, Social Security, or workers' compensation.

In any case, however, the plan will always pay a minimum benefit equal to the greater of:

- **$100 per month, or**
- **10% of the benefit based on your monthly income loss.**

The maximum monthly benefit for basic coverage is $6,000. The maximum monthly benefit for the buy-up optional coverage is $8,000.

Your LTD coverage and the amount you pay for coverage may change during the year as your pay changes.

Your LTD deductions are post-tax. Therefore, the LTD benefits you receive will not be taxed. This means that the buy-up portion of your LTD benefit will be on a tax-free basis. The LTD benefit you receive on the Core LTD plan is a taxable LTD benefit since the premium for the Core LTD plan is entirely employer-paid.

Consult your tax advisor for taxability questions related to your LTD benefit.

If you elect LTD coverage that is higher than your current level, you will not be covered for the new or increased amount for any disability related to a pre-existing condition during the first 12 months after the effective date of the new or increased coverage.

How Long LTD Benefits Continue

The length of time LTD benefits are paid depends on your age at the time of disability, as shown (all other plan limitations apply):

When Disability Starts	Maximum Benefit Period
Under age 61	To your normal retirement age, but not less than 60 months
Age 61	To your normal retirement age, 48 months
Age 62	To your normal retirement age, 42 months
Age 63	To your normal retirement age, 36 months
Age 64	To your normal retirement age, 30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and older	12 months

Making Your LTD Decision

To decide what level of LTD coverage is most appropriate for you, it may be helpful to ask yourself these questions:

- **Does your family have other financial resources if something happens that keeps you from working for a long time?**
- **Do you have any illness that could keep you from working for long periods of time (90 days or more)?**
- **Would you like extra financial protection just in case an injury or illness should keep you from working for an extended period of time?**

Hyatt Group Legal Insurance

YOU CAN CHOOSE:

- **Group Legal Plan**
- **Waive Coverage**

Participation in the Group Legal Plan provides you with access to a nationwide network of experienced attorneys who are available at an affordable price whenever a legal need arises.

If you need legal assistance, you will be referred to a participating attorney who can help you with a variety of services, including:

- **Civil and criminal matters**
- **Family law, including adoption and guardianship**
- **Living trusts**
- **Personal injury**
- **Purchase, sale, or refinancing of your home**
- **Wills and estate planning**
- **Bankruptcy**
- **Identity theft**

You will not pay for covered services that are provided by a plan attorney, although you will pay for third-party expenses such as filing fees, court costs, and witness or deposition expenses.

You may elect or waive coverage in the program every year during Open Enrollment or if you have a qualified change in status. If you elect coverage during this year's Open Enrollment, you and your dependents will be covered by the plan for 2012. You will pay for coverage with after-tax dollars.

If you are anticipating any legal expenses in 2012, you might consider signing up for legal coverage.

Flexible Spending Accounts

SJE/RMH offers two Flexible Spending Accounts: the Health Care Reimbursement Account and the Dependent Day Care Reimbursement Account. Participation is completely voluntary.

The advantage of using these accounts is tax savings. You set aside money from each paycheck on a pre-tax basis. That means your taxable income is lower and, therefore, you pay fewer taxes.

To be reimbursed for an eligible expense, simply submit a claim form and your receipts. You may also use your Healthcare Payment card, a prepaid card that can be used to pay for many routine expenses, such as doctor's office visits and prescription drugs. If you use the Healthcare Payment card, please save your receipts. Our plan administrator may request a record of your transactions to substantiate expenses..

Health Care Reimbursement Account

YOUR OPTIONS ARE:

- **To deposit $100 to $5,000 per plan year**
- **No Participation**

You can use this account to reimburse qualified health care expenses, including copayments, coinsurance, amounts over usual, customary, and reasonable limits, health care expenses your insurance plans don't cover, prescription drug copayments, and certain over-the-counter products.

You can use this account for eligible expenses incurred by you, your spouse, or your dependents if you pay more than half of their support and can claim them as a dependent on your federal income tax return. Your dependents do not need to be covered under your health insurance to be eligible for claims reimbursement from the Health Care Reimbursement Account.

IRS Rules Govern Substantiation Requirements

The IRS has established specific guidelines that require all Flexible Spending Account (FSA) transactions — even those made using a healthcare payment card — to be substantiated (verified that the purchase was an eligible medical expense).

Always Save Itemized Receipts!

You should save your itemized receipts from every healthcare payment card transaction and all of the explanation of benefits (EOBs) received from health/pharmacy/dental plans.

An easy approach for keeping this information on hand is to designate one envelope or folder to store all itemized healthcare payment card receipts and EOBs. Using this process will help you find documentation if requested.

How will I know if I need to submit a receipt for substantiation?

You will always have to submit receipts anytime you request reimbursement online from your Flexible Spending Account (FSA). **If a receipt is needed for a healthcare payment card claim, you will be notified by email or letter.** You can also review if your claim requires receipts online by logging into your account and visiting the Claim Center. You need to submit receipts if you see a notice.

Common Misconceptions about Receipt Requirements

1. If the healthcare payment card is used for an eligible service, no further receipts or documentation are needed to support the expense.
2. Any claim at a doctor, dentist or vision provider will not require receipts.

These misconceptions are **NOT TRUE**! Since not all services from a medical provider or pharmacy are eligible medical expenses, receipts are required to verify eligibility. For example, a dentist may perform teeth whitening, which is not eligible for reimbursement.

Important Reminders

Over-The-Counter Medications

Over-The-Counter (OTC) medications do not qualify as a reimbursable medical expense under IRS Code Section 213(d) and are not eligible for reimbursement through the Health Care Reimbursement Account **unless prescribed by a physician**. The OTC limitation pertains to drugs and medicine only, therefore certain OTC items, such as bandages and contact lens solution, are still eligible (refer to chart for examples). Ineligible expenses incurred will not be reimbursed.

Please take this into consideration when determining your annual election for the Health Care Reimbursement Account as it may change the amount of your election.

Examples of items not eligible without a prescription for reimbursement

Category	Example
Allergy and Sinus	Alavert, Benadryl, Claritin, Sudafed
Cough, Cold and Flu	Robitussin, Theraflu, Vicks, Halls, Cepacol, Zicam, Cold-Eeze
Motion Sickness	Dramamine, Sea-band wristbands, Bonine
Pain Relief (including aspirin)	Tylenol, Advil, Motrin, Bayer
Sleep Aids & Sedatives	Unisom, Nytol, Sominex

Example of items eligible for reimbursement

Category	Example
Supplies	Bandages, Gauze
Baby Electrolytes and Dehydration	Pedialyte, Enfalyte
Eye Care	Contact Lens Care, Visine, Refresh Tears
Hearing Aids	Hearing Aids, Hearing Aid Batteries

A detailed list of eligible expenses is available at the Benefit Service Center Web site or by speaking with a benefits representative.

Dependent Day Care Reimbursement Account

YOUR OPTIONS ARE:

- **To deposit $100 to $5,000 per plan year***
- **No Participation**

** You cannot deposit more than your or your spouse's earned income to this account. If you are married and file separate income tax returns, you may deposit a maximum of $2,500.*

You can use this account to reimburse qualified Dependent Day Care expenses so you (and your spouse, if applicable) can work. For this account, your eligible dependents are your dependent children under age 13 or anyone who is physically or mentally incapable of self-care and spends at least eight hours a day in your home.

Eligible expenses include fees paid to providers outside your home (e.g., an adult or childcare center) and payments to baby-sitters (other than your dependents) or caregivers who provide dependent day care in your home.

Important Note: You must provide the taxpayer identification number of the person or organization providing the care. Do not use this account if your day care provider does not have this number (for example, if your provider is not a legal resident).

Dependent Care Tax Credit or Reimbursement Account

You have the choice of using the Dependent Day Care Reimbursement Account, the federal tax credit, or a combination of both.

The approach that is right for you will depend on your family income and the number of dependents receiving day care. In general, if your family's adjusted gross income is more than $40,000, you will save more in taxes using the reimbursement account; however, you should consult your tax advisor to determine which method will save you more money.

Flexible Spending Accounts

Important IRS Rules

Because of the tax advantages the IRS has special rules for using the Reimbursement Accounts.

- **You cannot reimburse health care expenses through the Dependent Day Care Account and vice versa.**
- **You will forfeit any money left in your account after the end of the claim-filing period (April 15, 2013); claims must have been incurred during 2012.**

Making Flexible Spending Account Decisions

To decide the amount of your annual contribution to either or both Flexible Spending Accounts, it may be helpful to ask yourself these questions.

For the Health Care Account:

- **Will you have any eligible health care expenses during the year that your medical or dental plans will not cover?**
- **Will you meet your medical plan deductible (if applicable) in the upcoming year?**
- **Are you or your covered dependents expecting to have any costly procedures or treatments, such as surgery or a new baby?**

For the Dependent Day Care Account:

- **Do you have children or dependents that meet the guidelines for dependent day care?**
- **Do you pay someone (other than your spouse or other dependent child) to take care of your children inside or outside your home?**
- **Are you a single parent with custody of your children?**

*Need help determining how much to contribute to your Health Care Reimbursement Account? Use the online **Savings Account Estimator** to help you determine the appropriate contribution.*

Here's an example of how the Health Care Savings Account could save you money:

Without an HCRA	With a HCRA
$30,000 income	$30,000 income
	–$2,000 annual contribution to Health Care Reimbursement Account based on estimated expenses
$30,000 taxable income	$28,000 taxable income
–$7,500 tax (25%)*	–$7,000 tax (25%)*
$22,500 net take home	$21,000 net take home
–$2,000 in medical expenses after taxes	You use your pre-tax contributions to pay for $2,000 in expenses
$20,500 total take home	**$21,000 total take home**
	You saved $500 in taxes! And paid for your medical expenses.

** This is an estimated income tax rate for this example. Your tax rate would include your federal, state, local, Social Security and Medicare taxes.*

Glossary

After-Tax Dollars—money (payroll deductions) taken from your paycheck after taxes are calculated. Coverage under the Dependent Life Insurance Plan, Supplemental Life Insurance Plan, Long-Term Disability Insurance Plan and Group Legal Plan is purchased with after-tax dollars.

Beneficiary—person or persons you name to receive benefits from a plan if you die.

Children—eligible dependent children include your natural children, stepchildren, legally adopted children, or children under your legal guardianship. Your LDM's unmarried children are also eligible, as long as they meet all the qualifications for dependent children.

Coinsurance—after you meet your deductible, the plan pays a percentage of your eligible expenses. The amount you pay is called your "coinsurance."

Copayment—the flat dollar amount you pay for most prescription drugs and for most services received from an PPO provider.

Deductible—the amount you pay under most medical and dental options before the plan begins to cover a portion of your costs.

Evidence of Insurability—any statement or proof of a persons' physical condition and/or other factual information affecting his/her acceptance for insurance.

Express Scripts—the company that administers the prescription drug program.

Formulary—a drug list that contains brand name and generic medications. A team of medical directors, physician providers, and pharmacists meets regularly to review and update the list. A copy of the ESI Prescription Drug Formulary is available from the Benefit Service Center.

In-Network—healthcare providers—including doctors and hospitals—who belong to a network. Medical options pay a greater share of your costs when you use in-network providers.

Legally Domiciled Member (LDM) —a person, other than a spouse or dependent child, who is a long-term member of your household, for example, a registered domestic partner, a parent who lives with you, an adult child who lives with you, or a child not yet adopted. To enroll an LDM, you must submit an affidavit declaring that your LDM meets the legal definition, and may need to prove that your LDM has been a member of your household for at least 12 consecutive months.

Open Enrollment—a period each fall during which you make your benefit elections for the following calendar year.

Out-of-Network—providers who are not members of our PPO plan's network. You generally will have to pay more for their services than you would if you received the same services from in-network providers.

Glossary

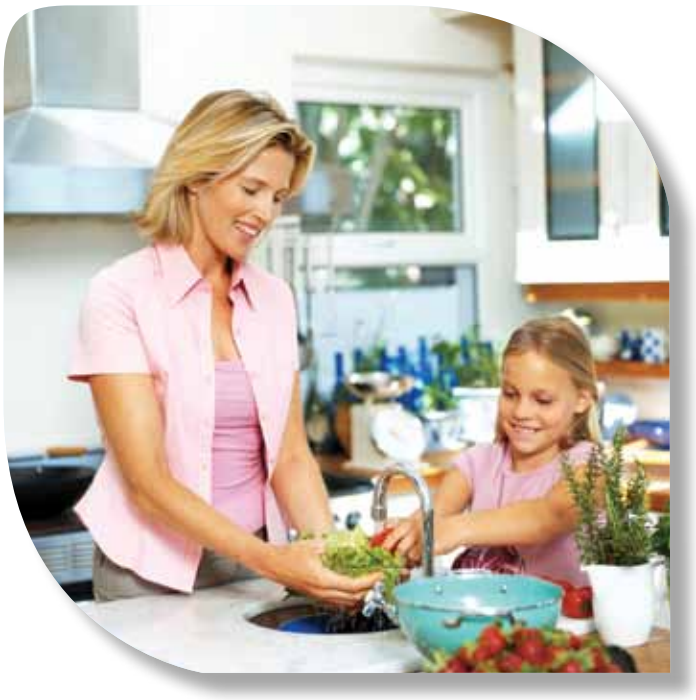
PPO (Preferred Provider Organization)—a health care network plan. PPOs give you the option of receiving care from an in-network or out-of-network health care provider.

Pre-Tax Dollars—the money taken from your pay before taxes are calculated. Deductions for all benefit options, except Dependent Life Insurance, Supplemental Life Insurance, Long-Term Disability Insurance and the Group Legal Plan are deducted from your paycheck before taxes are withheld. Paying for benefits with pre-tax dollars lowers your taxable income, resulting in fewer income taxes to pay.

Registered Domestic Partner (RDP)—an adult who has filed, along with you, a Declaration of Domestic Partnership with the California Secretary of State. To enroll an RDP, you must submit the necessary paperwork to declare that your RDP meets the legal definition.

Qualified Change in Status—a life event that allows you to make a change to certain benefit elections at a time other than Open Enrollment, such as marriage and divorce, birth of a child, loss of eligibility for coverage, etc. A more complete list appears on page 5. To request a change, you must contact the Benefit Service Center within 31 days of the event.

Usual, Customary, and Reasonable (UCR) Charges—a charge is "usual, customary, and reasonable" if it's not more than the current range of fees charged for the same service or supply by doctors, or other providers of medical services, in the same local area. Amounts over the UCR limits are not covered expenses under the medical and dental options.



Employee Benefits Contact List *and* Web Sites

	Telephone Number	Web Site
Benefit Service Center	800-306-4363	From *CAREnet*, select *MyHR* under the *HR & Benefits* tab. Login to *MyHR* using your PeopleSoft user ID and password and click the *Benefit Service Center* link.*
Delta Health Systems	888-533-7025	www.deltahealthsystems.com
Delta Dental DPO	800-765-6003	www.deltadentalca.org
Diversified Investment Advisors (401(a) Plan and 401(k) Plan)	800-755-5801	www.divinvest.com
Employee Assistance Program (EAP)	707-443-1303	n/a
Express Scripts	888-387-0448	www.express-scripts.com
Healthways	877-393-0478	From *CAREnet*, select *MyHR* under the *HR & Benefits* tab.
Hyatt Group Legal Plan	800-821-6400	www.legalplans.com
MetLife Long-Term Disability Group Life/AD&D	877-ASK MET7 877-275-6387 800-638-2242 800-638-6420	www.metlife.com
VSP Vision Care (VSP)	800-877-7195	www.vsp.com

**If you are unable to access CAREnet because you have an unsupported internet browser, you may access the MyHR Web site directly at https://myhr.stjoe.org. If you need assistance with your CAREnet or PeopleSoft User ID & Password, please call the IT HelpDesk at 877-552-7547.*

*This Enrollment Guide provides important enrollment information for the **Benefits for a Better Way of Life** benefits program. Complete details about the plans are in the legal plan documents that govern the options and plan administration. If there is any difference between the information in this kit and the provisions of the official plan documents, the plan documents will govern.*

St. Joseph Health System intends to continue this benefit program, but reserves the right to terminate, suspend, withdraw, amend, or modify the plans at any time in accordance with the provisions of the group policies and the plan documents.

ST. JOSEPH HEALTH SYSTEM

Covenant Health System

ST.1-OPM-2012-BR-2
B01/B02