A Guide to Your Benefits

2022

LUTHER COLLEGE

Welcome to Luther College's 2022 Open Enrollment! We are pleased to offer a wide range of benefits to meet the needs of you and your family for the upcoming plan year. Open enrollment is your once-a-year opportunity to review your benefit needs and make elections for 2022.

In the pages that follow, we have summarized the 2022 benefit offerings. Please consult this guide carefully.

If you have any questions, please contact the HR Department via e-mail at: hr@luther.edu or call: 563-387-1134.

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If you would like to make changes for 2022 – Please complete your enrollment form(s) and return to HR by November 19, 2021

Important Dates

- **Thursday, November 4 through Friday, November 19, 2021 –** Open Enrollment period – if you would like to make changes to any of your plans, you must complete and return your enrollment form(s) to HR. Changes will be effective January 1, 2022.

- **Open Enrollment Meetings:**

	Details
Thursday, November 4th at 4:00 pm	In-person at the Peace Dining Room
Friday, November 5th at 9:15 am	In-person at the Peace Dining Room
Monday, November 8th at 11:00 am	**Zoom Passcode info** a. Open https://zoom.us/join b. Enter Meeting ID - 997 9014 4668 c. Enter password - 019116 d. Follow prompts to connect to computer audio, or dial in to the meeting audio

- **Friday, November 19, 2021 –** Enrollment form(s) are due to HR.

What Do I Need to Do?

- Review the information in this guide and decide on your benefit elections for 2022**.**

- If you are making changes to your health care coverage, you must return your 2022 health care open enrollment form by **November 19, 2021**

  - **2021 FSA benefit plan elections will NOT roll over into 2022 automatically. You must complete an election form to continue FSA benefits in 2022**
  - **All plans EXCEPT FSA will roll over into 2022 automatically if you do not turn in a form**

- If you are enrolled in the Health Care FSA in 2021 and are choosing to elect the HDHP option for 2022, you MUST have a zero balance in your Health Care FSA as of December 31, 2021 to be eligible to contribute your own money to the Health Savings Account (HSA) on January 1, 2022; if your balance in the FSA is not $0 on January 1, 2022, you may not contribute to your HSA until April 1, 2022

Did you know? You don't have to enroll your family members in all the plans and coverage you elect for yourself. For example, you may cover yourself and your dependents for medical benefits, but cover only yourself for dental.

The benefit elections you make during Open Enrollment begin January 1, 2022 and will stay in effect until December 31, 2022. You cannot change your benefits during the year unless you have a change in your family or employment status (called a qualified change in status or life event).

Open Enrollment is November 4, 2021 through November 19, 2021

What Is Changing?

Health Care Rates: The College has made the commitment for employee premium contributions to remain unchanged for 2022 while plan changes being implemented will require employees to potentially pay more out-of-pocket as services are utilized.

Luther College health care costs are increasing by 11.2%. The national average for comparable employer-funded health care plans is 7%. Prior to 2018, the Luther College Health Care Plan out-performed the national average. Significant health plan utilization over the past 3 years have driven expense projections well above the national average.

Based upon current enrollment, the total 2022 health care budget is $6.3 million. The college will contribute approximately 73.7%, or $4.7 million. The total employee contributions will be approximately 26.3%, or $1.7 million. In lieu of making any changes to the employee payroll contributions, Luther made the decision to alter plan designs for 2022.

Health Care Plan Changes: Luther College will continue to offer PPO and HDHP plan options. There are changes to the plan designs for 2022, please review the side-by-sides on Page 6 for the new designs.

Teladoc & Convenience Care Changes: Teladoc consultations and convenience care, such as walk-in clinics found at retail locations like CVS, Walgreens, Target, and Hy-vee, will be $20 per visit for PPO members. HDHP members will pay the full cost of the visit and then may submit a claim form to UMR to apply the amount to the deductible and out-of-pocket maximums.

In 2022, members will also have access to the following services through Teladoc:

Dermatology $85/visit
Psychiatrist Initial $220/visit and Psychiatrist Ongoing $100/visit
Non-Psychiatrist Visit (licensed therapist) $90/visit

Dental Plan Rates*:* There are slight increases to the employee contributions with no plan design changes

Health Savings Account: The 2022 IRS maximum employee contribution limits are $3,650 for individual coverage and $7,300 for family coverage (includes employee + 1 or family tier).

Flexible Spending Accounts: Healthcare flexible spending accounts and dependent care reimbursement accounts must be updated each year in order to remain active (see page 14).

Limited Flexible Spending Account: If you choose to enroll in the HDHP medical plan, you will be able to enroll in the Limited Healthcare Flexible Spending Account.

Ancillary Coverage – Voluntary Life: If you have not enrolled in the plan previously or would like to increase your amount of coverage, you have the opportunity to enroll during open enrollment with evidence of insurability.

Who Do I Contact for Help?

If you have questions about enrollment or eligibility, please contact the HR Department via email at hr@luther.edu or call 563-387-1415

Retirement - TIAA Defined Contribution Plan

Luther College is a member of the Iowa Independent Higher Education Research Foundation (IIHERF) and the Iowa Association of Independent Colleges and Universities (IAICU), Multiple Employer Plan (MEP). TIAA is the recordkeeper and custodian for the MEP plan, and you can review your investment accounts using the TIAA/Luther College microsite (https://www.tiaa.org/public/tcm/luther) .

Educational services are available at no additional cost through Millennium Advisory Services, Inc. If you meet the eligibility requirements, the College will contribute an amount equal to 5% of an employee's base salary as long as you contribute at least 3%. You may choose either pre-tax or after-tax (Roth) options for your employee contributions. To make changes to your contributions:

- Complete the IAICU Multiple Employer Plan Salary Deferral Agreement found on the HR website https://www.luther.edu/hr/faculty-staff/common-forms/
- Bring the completed form to the Office of Human Resources, Main 25
- The deduction change will be implemented as soon as administratively possible based on the next available payroll date

Wellness Program

Please note that the Luther College Health Care Plan covers 100% of a community wellness blood panel and routine physical exam for employees and their dependents each year.

As part of Luther College's wellness initiatives, 2022 carries additional health care requirements for employees and their spouses enrolled in the Luther College Health Care Plan. In early 2022 employees will be receiving additional information on the steps to be completed. There will be a link to the health risk assessment, the wellness check-up form, and more information about the community wellness blood panel. By December 31, 2022, employees (and participating spouses) enrolled in the health care plan will be required to complete the following:

1. Complete a Community Wellness blood panel
2. Fill out a clinical health risk assessment (CHRA)
3. Complete a routine physical exam (It is recommended that you take your blood screening and CHRA results to the exam.)
4. Fill out the Wellness Check-up Form and return to Human Resources. This document is available on the Human Resources website at https://www.luther.edu/hr/faculty-staff/common-forms/

Employees who complete the above four steps by December 31, 2022, will avoid the additional health care premium of $25.00 per month which will otherwise begin on January 1, 2023.

2022 Medical Plan Information

Luther College will continue to offer two different medical benefit plan options through UMR and RxBenefits. Both plans feature a broad network of doctors, hospitals and other health care providers. To locate an in-network provider, go to www.UMR.com and click on "Find a provider"; for details on RxBenefits, please visit contact RxBenefits Member Services at 1-800-334-8134 or RxHelp@rxbenefits.com.

All Details Shown for In-Network Benefits	**$1,000 PPO Plan ("Traditional" Plan)**	**High Deductible Health Plan (HDHP)**
Medical Deductible		
Single	$1,000	$3,000
EE+1 or Family	$2,000	$6,000
Medical Out-of-Pocket (OOP) Max		
Single	$4,500	$4,500
EE+1 or Family	$9,000	$9,000
Office Visits		
Preventive	**Plan Pays 100%**	**Plan Pays 100%**
Primary Care/Urgent Care	$40 Copay	Deductible then 90%
Convenience Care/Telemedicine (CVS, Walgreens, Target, Teladoc, etc.)	$20 Copay	Deductible then 90%
Specialist	$40 Copay	Deductible then 90%
PT/OT/ST, Chiropractic, Acupuncture	$40 Copay	Deductible then 90%
Professional Services		
Mental/Behavioral Health	Deductible then 80%	Deductible then 90%
Emergency Room	Deductible then 80%	Deductible then 90%
Diagnostic (Lab)	Deductible then 80%	Deductible then 90%
Diagnostic (X-ray, MRI, CT Scans)	Deductible then 80%	Deductible then 90%
Hospital		
Inpatient and Outpatient	Deductible then 80%	Deductible then 90%
Prescription		
Preventive Rx	**Plan Pays 100%**	**Plan Pays 100%**
Generic	$10 Copay	Deductible then 90%
Preferred Brand	$40 Copay	Deductible then 90%
Non-Preferred Brand	$75 Copay	Deductible then 90%
Specialty	Member pays 20% up to $200	Deductible then 90%

Important Notes:

- This is a synopsis of coverage only; the Summary Plan Description (SPD) contains exclusions and limitations that are not shown here. Please refer to the SPD for the full scope of coverage.
- In-network services are based on negotiated charges

2022 Medical Plan Rates

As in past years, how much you pay out of your paycheck for Luther College's medical plans depends on your plan selection, your annual salary, and who you are covering on the plan. Please note that the Total Monthly Premiums listed below are estimates at this time and may change. The college has committed to holding the employee contribution rates flat. Rates for 2022 are as follows:

Monthly Rates	Plan Option 1 $1,000 PPO	Plan Option 2 - $3,000 HDHP with HSA	Plan 1 vs. Plan 2 Annualized Difference
Single Coverage			
Total Monthly Premium	$756	$706	
Employee Monthly Contribution:			
Salary Tier 1 (<$35,000)	$115	$92	$276
Salary Tier 2 ($35,000 - $58,000)	$140	$117	$276
Salary Tier 3 (>$58,000)	$174	$151	$276
Employee + 1 Coverage			
Total Monthly Premium	$1,428	$1,333	
Employee Monthly Contribution:			
Salary Tier 1 (<$35,000)	$305	$262	$516
Salary Tier 2 ($35,000 - $58,000)	$439	$396	$516
Salary Tier 3 (>$58,000)	$556	$513	$516
Family Coverage			
Total Monthly Premium	$1,979	$1,837	
Employee Monthly Contribution:			
Salary Tier 1 (<$35,000)	$368	$302	$792
Salary Tier 2 ($35,000 - $58,000)	$512	$446	$792
Salary Tier 3 (>$58,000)	$648	$582	$792

- Employee + 1 includes the following situations:
  - Employee + Spouse
  - Employee + 1 Child (no Spouse)
- Both Spouses employed at Luther College with no children should elect two single coverages
- Both Spouses employed at Luther College with family coverage – Employee Contribution is based on the higher salary level

Health Savings Account (HSA)

If you enroll in the HDHP option, you may be eligible for a college sponsored Health Savings Account (HSA), administered by Optum Bank (a UMR "sister" company). *(See eligibility requirements below.)*

HSAs offer you the following advantages:

- **Tax Savings.** You contribute pre-tax dollars to the HSA. Interest accumulates tax-free and funds are tax-free to withdraw for qualified medical expenses--the same expenses that qualify under the Flexible Spending Account (FSA).
- **Reduce your out-of-pocket costs.** You can use the money in your HSA to pay for eligible medical expenses and prescriptions. The HSA funds you use can help you satisfy your HDHPs annual deductible.
- **Invest the funds and take them with you.** Unused account dollars are yours to keep even if you retire or leave the company. Additionally, you can invest your HSA funds, so your available health care dollars can grow over time.
- **The opportunity for long-term savings.** Unlike Flexible Spending Accounts (FSAs), HSAs do not have a "use it or lose it" rule. Unused HSA funds rollover from year to year—money you can use to reduce future out-of-pocket health expenses. You can even save HSA dollars to use after you retire.

What You May NOT Know About HSAs:

- **You have to meet the following requirements to be eligible to contribute to the HSA:**
  - You must be covered by a qualified HDHP
  - You cannot be enrolled in Medicare
  - You cannot be covered under other non-qualified health insurance (ex: Tricare, Indian Nation Plan)
  - You cannot be covered by another "full" medical Flexible Spending Account (FSA) (through a spouse)
  - You cannot be claimed as a dependent on someone else's tax return

- **Contributions to the HSA:**
  - Each year, the IRS sets HSA annual contribution limits, the 2022 limits are as follows:
    - $3,650 for individual coverage
    - $7,300 for family coverage (includes employee +1 or family tier)
  - If you (the account holder) are over age 55, you can contribute an additional $1,000 over the IRS limit
  - Contributions remain in the HSA from year to year until they are used – no use it or lose it!
  - You can increase/decrease your optional contribution to the account throughout the year

Distributions from the HSA:

- Distributions from your HSA are tax-free if they are taken for "qualified medical expenses."
- Much like a standard checking account, HSA funds may be used as long as funds are deposited in the account.
- HSA distributions can be taken for qualified medical expenses for the following people:
    - The account holder (person covered by the qualified HDHP)
    - Spouse of that individual (even if not covered by the qualified HDHP)
    - Tax dependents of that individual (even if not covered by the qualified HDHP)
- You may use your HSA dollars even if you are no longer covered by a qualified HDHP.
- You may use HSA money for non-qualified expenses…BUT…
    - You'll pay income taxes, AND
    - A 20% tax penalty

Information about Optum Bank HSA Administration

- Luther College will "sponsor" your HSA if you choose Optum Bank as your administrator; by selecting Optum Bank as your administrator, you are eligible for:
    - Pre-tax payroll deduction employee contributions to the HSA
    - No HSA administration cost to you
- You must complete two forms to set up the HSA and return them to HR
    - Appointment of Employer as Authorized Agent to Open an HSA
    - Health Savings Account Payroll Election Form
- Optum Bank provides several convenient ways to submit a claim for reimbursement from your HSA:
    - Swipe your HSA debit card at places where you and your family members receive health care services
    - Request a distribution payment online
    - Complete and submit a Distribution Request Form and payment is sent to you by check or direct deposit

Additional information can be found in the Optum Bank materials available online and/or from HR.

Reminder:

If you are enrolled in the Health Care FSA in 2021 and are choosing to elect the HDHP option for 2022, you MUST have a zero balance in your Health Care FSA as of December 31, 2021 to be eligible to contribute your own money to the Health Savings Account (HSA) on January 1, 2022; if your balance in the FSA is not $0 on January 1, 2022, you may not contribute to until April 1, 2022.

RxBenefits – Member Services Pharmacy FAQs

How do I use my prescription benefits?

Your plan's pharmacy services and network is administered by one of the nation's largest pharmacy benefit managers. The combined experience and commitment to the member services of RxBenefits and your pharmacy benefits managers will help promote better health and value for millions of members.

If your coverage includes a pharmacy benefit, your health benefit plan ID card is also your prescription drug card. If your pharmacy coverage is a stand-alone plan, you will have a separate pharmacy ID card. Simply present your ID card and prescription at a participating retail pharmacy of your choice. The pharmacist will use your prescription and member information to determine your co-payment or co-insurance. Most plans allow you to receive up to a 30-day supply of covered medications at a retail pharmacy. Depending on your benefit, you may also be able to order medications using your plan's Home Delivery Pharmacy (home delivery). Consult the terms of your policy and any related riders or Summary of Benefits for full details about your prescription drug benefits, if they apply.

Order online.

Order refills, check status, find a pharmacy and more – anytime, anywhere, from your plan's pharmacy website or MOBILE application available to you at your fingertips.

How do I access my retail pharmacy network?

We offer access to a broad retail pharmacy network that includes thousands of pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are - at home, work or even on vacation. For a list of participating pharmacies, access your plan's website for more information

You'll get the most from your benefits by using a participating pharmacy. Choosing a non-network pharmacy means you'll pay the full cost of the prescription up front. Then you must submit a claim form to your plan for reimbursement.

How do I order medications using home delivery?

If your coverage includes a pharmacy benefit and you take maintenance medications, you can typically get a 90-day supply of your medication for the same price as two 30-day prescriptions filled at a retail pharmacy. Check your policy terms for details. Home delivery is a service for members who take maintenance medications such as for hormone replacement, asthma, diabetes, high blood pressure, arthritis, and any other conditions that require you to take a drug on an ongoing basis. It offers the convenience of having prescriptions filled using home delivery.

Simply pick up the phone or submit your order online, and your medications are delivered directly to your home, office or anywhere in the United States. To order refills of your medications online if you have home delivery, log into your plan's website.

What is a Drug List/Formulary?

Your plan uses what is called a "Preferred Formulary" that we also refer to as the "drug list" or just the "formulary." This drug list/formulary contains brand-name and generic medications approved by the Food & Drug Administration (FDA) that have been reviewed and recommended by your plan's Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an independent group of practicing doctors, pharmacists, and other healthcare professionals responsible for the research and decisions surrounding our drug list. This group meets regularly to review new and existing drugs and chooses the medications for our drug list - based on various factors, including their safety, effectiveness, and value.

If your doctor prescribes a drug that is not listed on the drug list, you may be subject to extra out-of-pocket costs. Because the medications on the drug list/formulary are subject to periodic review, call the Member Services number on the back of your ID card to determine which medications are included. To obtain a copy, you can also get this information online by logging into your plan's website.

What if my medication is not on the Drug List/Formulary?

If a drug your doctor prescribes is not on our drug list/formulary, please talk with your doctor about prescribing a medication that is on the drug list/formulary when appropriate. If a medication is selected that is not on your drug list/formulary; you will be responsible for the applicable non-formulary cost share amount.

The inclusion of medication on the drug list/formulary is not a guarantee of coverage. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your Summary of Benefits for coverage limitations and exclusions.

What is a prior authorization?

Certain prescription drugs (or the prescribed quantity of a drug) may require a "prior authorization" before you can fill the prescription. Some drugs require prior authorization because they may not be appropriate for every patient or may cause side effects. Your doctor should have a current list of drugs requiring prior authorization. However, your doctor may call your plan's referral number for authorization and information regarding these requirements. Prior authorization helps promote appropriate utilization and enforcement guidelines for prescription drug benefit coverage.

RxBenefits – Member Services Pharmacy FAQs

What do I need to do if one of my prescriptions requires a prior authorization?

Your doctor should have a current list of drugs requiring prior authorization. When you fill your prescription at a retail pharmacy, your pharmacist will be notified that your medication requires prior authorization and will take the necessary steps to request it. If you use home delivery, your doctor must obtain prior authorization before you can fill your prescription.

What are medication quantity limits?

Taking too much medication or using it too often isn't safe and may even drive up your health care costs. Quantity limits regulate the amount of medication covered by your plan for a certain length of time. Most plans cover a 30-day retail pharmacy supply or up to a 90-day supply using home delivery. Quantity limits follow U.S. Food and Drug Administration (FDA) guidelines, as well as manufacturer recommendations.

If you refill a prescription too soon or your doctor prescribes an amount higher than recommended guidelines, our pharmacy system will reject your claim. When this happens, the pharmacist receives an electronic "Invalid/Excessive Quantity" message. If your doctor believes your situation requires an exception, he or she may request prior authorization review.

When I submit a prescription, and my pharmacist receives an age or gender edit, what does that mean?

Certain drugs approved by the FDA or other prescribing guidelines include provisions that they are not appropriate for use based on a person's age or sex.

If you submit a prescription that is impacted by these requirements, the pharmacy computer will receive an electronic message of "Indication Not FDA Approved" (gender edit) or "Non-Covered Prescription Item" (age edit). This lets the pharmacist know that your prescription drug plan will not cover the medication as prescribed. However, the prescribing physician may determine that important medical reasons exist for prescribing this medication as written. If this is the case, the physician may request prior authorization review.

What is the difference between generics and brands and how does it affect my benefits?

Brand-name Drug: A brand-name drug is usually available from only one manufacturer and may have patent protection.

Generic Drug: A generic drug is required by law to have the same active ingredients as its brand-name counterpart but is normally only available after the patent expires on a brand-name drug. You can typically save money by using generic medications.

RxHelp@rxbenefits.com
1-800-334-8134; 7 am – 8 pm CST Monday - Friday

Be sure to check your Summary of Benefits to see how the use of generic versus brand-name drugs may affect your benefits and out of pocket costs. You may save money by using generic medications.

Are generic medications as safe and effective as brand-name drugs?

Yes. Generic medications are regulated by the FDA. In order to pass FDA review and be A-rated, the generic drug is required to be therapeutically equivalent to its counterpart brand-name medication in that it must have the same active ingredients, and the same dosage and strength.

Why are generic medications less expensive?

Normally, a generic drug can be introduced to the market only after the patent has expired on its brand-name counterpart and can be offered by more than one manufacturer. Generic drug manufacturers generally price their products below the cost of the brand-name versions.

Why are generic drugs important?

Depending on your benefit design, you can help control the amount you pay for your prescriptions by requesting that your doctor prescribe generic medications whenever appropriate.

How can I request a generic medication?

Your physician and pharmacist are the best sources of information about generic medications. Simply ask one of them if your prescription can be filled with an equivalent generic medication.
You may be subject to higher cost sharing for brand drugs.

Can I have my prescription switched to a drug with a lower co- payment?

If your current prescription medication is not a generic, call your doctor and ask if it's appropriate for you to switch to a lower cost generic drug. The decision is up to you and your doctor.

You can also select lower cost options from your plan's website where you manage your current prescriptions. You'll get information to discuss with your doctor and the tools to get started.

If I am going to be out of town for an extended time, how do I get an extra supply of drugs to cover me through that period?

If you are going to be out of town for an extended period and need medication, call the member services number on the back of your member ID card to request a vacation override. You must provide them the date when you are leaving and returning. The override will then be placed and you will pick up your medication at your local pharmacy.

Teladoc

Teladoc®

Teladoc provides live telephonic or face-to-face consultations using video with trusted, licensed doctors who can discuss your health issues, provide diagnoses and prescribe medications, if appropriate, in ***most*** states. Visit the website at www.Teladoc.com for more information. Teladoc is available from 24 hours a day, 365 days a year, including weekends and holidays.

PPO members will pay $20 per consultation and HDHP members will pay the regular fee for Teladoc are $49 per consultation. You will pay for the consultation and you may then complete a UMR claim form to submit the claim through your medical insurance, depending on where you are at with your out-of-pocket maximums, the medical plan may reimburse all or part of your expense. Regardless of how much the plan covers, the Teladoc visit will be significantly more affordable than an office, urgent care, or ER visit.
Typical concerns that can be addressed through Teladoc:

- □ Cold, flu symptoms
- □ Upper respiratory infections
- □ Allergies
- □ Children's health issues
- □ Aches and pains
- □ Wellness
- □ Medication advice
- □ Advice for family members

Dermatology $85/visit
Psychiatrist Initial $220/visit and Psychiatrist Ongoing $100/visit
Non-Psychiatrist Visit (licensed therapist) $90/visit

Employee Assistance Program

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor who can help you. When contacting the EAP you may be required to refer to the name **Iowa Private Colleges.** A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Medical and dental bills
- Anger, grief and loss
- Child and elder care
- Legal questions
- Identity theft
- Financial Services

Help is easy to access:

- **Online/phone support:** unlimited, confidential, 24/7.
- **In-person:** You can get up to 3 visits available at no cost to you with a Licensed Professional Counselor. Your counselor may refer you to a resource in your community for ongoing support.

Who is covered?

Unum's EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits, available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Travel Assistance

Whenever you travel 100 miles or more from home be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Services include:

- Multilingual services 24/7
- Hospital admission assistance
- Emergency medical evaluation
- Legal and interpreter referrals
- Economy round-trip common carrier transportation for a relative/friend if you are alone and going to be hospitalized more than seven days
- Call 1-800-872-1414 within the US or +609-986-1234 outside the US

Download and activate the app today from the Apple App Store or Google Play.

Reference Number: 01-AA-UN-762490

Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Luther College offers you a Delta Dental of Iowa dental plan. To locate an in-network dentist, go to www.deltadentalia.com and choose "Provider Search". The PPO Network provides deeper discounts, but Luther College also offers the Premier network, which includes more dentists than the PPO Network.

Monthly Premiums	Delta Dental
Single Family	$37 $80
Services	**In-Network**
Annual Deductible (Individual/Family)	$30/$90
Annual Maximum (per person)	$1,000
Diagnostic and Preventive Care: Includes cleanings, fluoride treatments, and x-rays	30% / 20% / 10% / 0% (Step Coinsurance based on years of active Delta coverage)
Basic Services: Includes fillings, white fillings on front teeth	30% / 20% / 10% / 0% (Step Coinsurance based on years of active Delta coverage)
Endodontics, Periodontics and Oral Surgery	30% / 20% / 10% / 0% (Step Coinsurance based on years of active Delta coverage)
Major Restorative Services: Includes crowns, bridges and full and partial dentures	50% after deductible (starting 2nd year on the plan)

Your dental plan includes Delta Dental of Iowa's Enhanced Benefits Program that links medical conditions and dental benefits at no additional cost to the employee. This benefit offers additional oral health services to subscribers with the following conditions:

Condition	Enhanced Cleaning Benefit	Fluoride Application
Cancer Related Chemo or Radiation	4 cleanings per year	Yes
Diabetes	4 cleanings per year	
High-Risk Cardiac Conditions	4 cleanings per year	
Kidney Failure or Dialysis	4 cleanings per year	
Periodontal (Gum) Disease	4 cleanings per year	Yes
Pregnancy	1 additional cleaning	
Suppressed Immune System	4 cleanings per year	Yes

For more details and to sign up for the Enhanced Dental Benefits Program, please contact Delta Dental of Iowa.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. Each pay period, funds are deducted from your pay on a pre-tax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Note: Remember, in order to receive reimbursements from your FSAs in 2022, you must use your debit card or submit claims information and receipts to UMR for payment

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,750 per year	Save on eligible expenses not covered by insurance; reduces your taxable income
Limited Health Care FSA	If you enroll in the HDHP, you can enroll in a limited Health Care FSA to cover dental and vision expenses only	Maximum contribution is $2,750 per year	Save on eligible vision and dental services; reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care and after school programs for children up to age 13, or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

Important Information about FSAs

Your FSA elections will be in effect through December 31, 2022 with a grace period through March 15, 2023 which is the date you must **incur** any eligible claims. Please plan your contributions carefully. Any money remaining in your account after March 31, 2023 (the date in which you have to submit for claims incurred 1/1/22 – 3/15/23) will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations.

The Advantages of an FSA

With an FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year

Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

Luther College provides 2 times your annual salary, up to $275,000, of Basic Life and AD&D Insurance to all eligible employees at no cost to you. The portion of the premium paid for life insurance coverage over $50,000 will, as required by the IRS, be added to your W-2 taxable income at year-end. In the event of an accidental death, the benefit increases to 4 times your annual salary.

Please make sure your beneficiary designation on file with Luther College is current!

You are also able to elect **supplemental life/AD&D** insurance for yourself, your spouse and children up to age 26. Options include:

- **Employee:** The lesser of 5X your base annual salary or $500,000, in $10,000 increments.
- **Spouse:** Requires employee enrollment. Up to 100% of employee amount in increments of $5,000, not to exceed $250,000.

  Child: Requires employee enrollment. Age 6 months to 19 years old (or up to 26 if they are full-time students) up to $10,000 per child in increments of $2,000. Age 0 - 6 months, maximum $1,000 benefit.

Important! If you have not enrolled in the plan previously or would like to increase your amount of coverage, you may enroll during open enrollment however are subject to evidence of insurability.

Long-term Disability (LTD) Insurance

LTD is a critical part of your financial security in the event that you are disabled and unable to work for an extended period of time, especially if others depend on you for support.

Luther College provides this benefit to you at no cost. The benefit will pay you 60% of your monthly earnings up to a maximum of $5,000 per month in the event you are disabled for more than 180 days.

For additional details on your LTD benefit, please contact HR for a policy document.

Contact Information

Plan	Whom To Call	Group #	Phone Number	Website
Medical Plan	**UMR**	**7670-00-412374**	**800-826-9781**	**www.umr.com**
Pharmacy Plan	**RxBenefits**	**RXBLUCO**	**800-334-8134**	**www.rxbenefits.com Email: RxHelp@rxbenefits.com**
Health Savings Account (HSA)	**Optum Bank**	**N/A**	**866-234-8913**	**www.optumbank.com**
Dental Plan	**Delta Dental of IA**	**92348**	**800-544-0718**	**www.deltadentalia.org**
Flexible Spending Accounts	**UMR**	**7670-02-412374**	**800-826-9781**	**www.umr.com**
Employee Assistance Program (EAP)	**Unum**	**N/A**	**1-800-854-1446**	**www.unum.com/lifebalance**
Travel Assistance	**Unum/Assist America**	**01-AA-UN762490**	**US: 1-800-872-1414 Outside US: (US access code) +609-986-1234**	**Email: medservices@assistamerica.com**
Life, Voluntary Life, and LTD Insurance	**Unum**	**691293 691294 335731**	**866-679-3054**	**www.unum.com**
403(B) Retirement Investment Plan	**TIAA**	**103157**	**1-800-842-2776**	**www.tiaa.org**
Luther College Office of Human Resources		**N/A**	**563-387-1415**	**hr@luther.edu**

About this Guide

This benefit summary provides selected highlights of the Luther College employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at Luther College. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between information provided through this summary and the actual terms of the policies, contracts and plan documents are governed by the terms of these policies, contracts and plan documents.

Luther College reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductible and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description of the plan you selected.

If you would like more information on WHCRA benefits, call your Plan Administrator.

HIPAA Special Enrollment Rights

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA - Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

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

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

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

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

Luther College's Commitment to You

This notice is intended to inform you of the privacy practices followed by the Luther College Medical Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on October 1, 2013.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Luther College requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

***As permitted or required by law*.** We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing

to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Luther College for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

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

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Director of Human Resources
Luther College
700 College Drive
Decorah, IA 52101
563-387-1415 + mwenthold@luther.edu

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

•Your hours of employment are reduced, or

•Your employment ends for any reason other than your gross misconduct.

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

•Your spouse dies;

•Your spouse's hours of employment are reduced;

•Your spouse's employment ends for any reason other than his or her gross misconduct;

•Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

•You become divorced or legally separated from your spouse.

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

•The parent-employee dies;

•The parent-employee's hours of employment are reduced;

•The parent-employee's employment ends for any reason other than his or her gross misconduct;

•The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

•The parents become divorced or legally separated; or

•The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the employee, beneficiary or their representative must give notice of the event according to the procedures outlined in this section. Failure to follow these procedures may result in the loss of eligibility for continuation coverage.

1. The notice must be in writing.

2. The written notice must be sent to the individual listed in #4 below within 60 days of the latest of:

    a. The event date

    b. The date the individual would lose coverage due to the event

    c. In the case of the employee's disability, the date of the disability determination by the Social Security Administration

3. The written notice must include the following information:

    a. The Name and Address of the individuals requesting continuation coverage or extension of continuation coverage

    b. A description of the event and event date

    c. If the event is due to the disability of the employee, a copy of the determination letter approving total disability status must be included

4. The written notice must be sent to:

Director of Human Resources
700 College Drive
Decorah, IA 52101
563-387-1415

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months for eligible spouses and dependents of an employee, and 18 month for eligible employees. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

If an employee becomes entitled to Medicare benefits then within 18 months experiences a qualifying event which is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage for eligible spouses and dependents lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent

children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Notice must be provided to the employer or administrator of the request for disability extension or second qualifying event extension. The employee, beneficiary or their representative must give notice of the event according to the procedures outlined in this section. Failure to follow these procedures may result in the loss of eligibility for continuation coverage.

1. The notice must be in writing.

2. The written notice must be sent to the individual listed in #4 below within 60 days of the latest of:

    a. The event date

    b. The date the individual would lose coverage due to the event

    c. In the case of the employee's disability, the date of the disability determination by the Social Security Administration

3. The written notice must include the following information

    a. The Name and Address of the individuals requesting continuation coverage or extension of continuation coverage

    b. A description of the event and event date

    c. If the event is due to the disability of the employee, a copy of the determination letter approving total disability status must be included

4. The written notice must be sent to:

Director of Human Resources
700 College Drive
Decorah, IA 52101
563-387-1415

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Luther College
Director of Human Resources
700 College Drive
Decorah, IA 52101
563-387-1415