A Guide to Your Benefits

2025

LUTHER COLLEGE

Welcome to Luther College's 2025 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 2025.

In the pages that follow, we have summarized the 2025 benefit offerings. Please consult this guide carefully.

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

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To have benefits in 2025, you must complete your enrollment on Norse Hub between October 31 and November 15, 2024

Important Dates

- **Thursday, October 31 through Friday, November 15, 2024 –** Open Enrollment period – if you would like to make changes to any of your plans, you must complete online open enrollment via Norse Hub by November 15, 2024. Changes will be effective January 1, 2025.

- **Open Enrollment Meetings:**

	Details
Friday, November 1st at 9:30 am **Friday, November 1st at 3:00 pm** **Monday, November 4th at 3:00 pm**	Virtual meeting via Zoom: a. Click: https://zoomto.me/5CsyV b. If prompted, enter Meeting ID: 966 2996 6968 c. If prompted, enter Passcode: 819322 Follow prompts to connect to audio via computer or phone

What Do I Need to Do?

- Review the information in this guide and decide on your benefit elections for 2025.

- If you are making changes to your elections, or if you wish to continue contributions to a flexible spending account, you must complete open enrollment online via Norse Hub by November 15, 2024. If you are not making changes or participating in the FSA, your benefits will automatically carry forward and you do not need to complete online benefit enrollment.

- See the Open Enrollment page on the HR website for detailed instructions and scheduled work sessions to help you through the online enrollment process.

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, 2025, and will stay in effect until December 31, 2025. 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).

Who Do I Contact for Help?

If you have questions about your benefits, please contact human resources via email at hr@luther.edu or call x1134.

Open Enrollment is October 31, 2024 through November 15, 2024

What Is Changing?

Health Care Salary Bands: The College is adjusting the salary bands used as the basis for contributions effective January 1, 2025 as follows:

Salary Tier	2024 Salary Band	2025 Salary Band
Tier 1	< $41,200	< $42,024
Tier 2	$41,200 - $61,800	$42,024 - $63,036
Tier 3	> $61,800	> $63,036

Health Care Rates: The College is increasing rates for the Single and Family tiers for both plans by approximately 2%. Rates for 2025 are found later in this guide

Based upon current enrollment, the total 2025 health care budget is $5.6 million. The college will contribute approximately 78.3% or $4.7 million. The total employee contributions will be approximately 21.7% or $1.3 million.

Health Care Plan Changes: Luther College will continue to offer PPO and HDHP plan options. The only significant plan change is that the HDHP plan deductibles are increasing slightly to match changes to IRS regulations.

Health Savings Accounts: If you enroll in the HDHP option for 2025 and meet the criteria to contribute to an HSA, Luther will continue to make college-funded contribution as follows:

HDHP Enrollment Tier	College HSA Contribution (Annual)	2025 IRS Maximum Contribution
Single	$300	$4,300
Employee + 1	$600	$8,550
Family	$900	$8,550

If you are enrolled in a Health Care FSA in 2024 and are choosing to elect the HDHP option for 2025, you MUST have a zero balance in your Health Care FSA as of December 31, 2024 to be eligible to receive the College contribution and contribute your own money to the Health Savings Account (HSA) on January 1, 2025; if your balance in the FSA is not $0 on January 1, 2025, you may not contribute to your HSA nor receive the College contribution until April 1, 2025.

Flexible Spending Accounts: Healthcare flexible spending accounts and dependent care reimbursement accounts must be updated each year in order to remain active **(see page 13).**

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.

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, please update your election online via Norse Hub.

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

2025 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, pharmacies, 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	$3,300
EE+1 or Family	$2,000	$6,600
Medical Out-of-Pocket (OOP) Max		
Single	$4,500	$4,500
EE+1 or Family	$9,000	$9,000
Annual College HSA Contribution		
Single	Not Applicable	$300
EE+1		$600
Family		$900
Office Visits		
Preventive	Plan Pays 100%	Plan Pays 100%
Primary Care / Urgent Care	$40 Copay	Deductible then 90%
Convenience Care	$20 Copay	Deductible then 90%
Teladoc – Virtual telemedicine offering virtual healthcare to patients through video and phone calls	$20 Copay	Deductible then 90% Price varies based on visit type, see page 14 for additional details
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%
Vision		
Children's Eye Exam	Plan Pays 100%	Plan Pays 100%
Adult Eye Exam	$150 benefit per calendar year	$150 benefit per calendar year

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

2025 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. Rates for 2025 are as follows:

Monthly Rates	Plan Option 1 $1,000 PPO	Plan Option 2 - $3,300 HDHP with HSA	Plan 1 vs. Plan 2 Annualized Difference
Single Coverage			
Total Monthly Premium	**$714**	**$665**	
Employee Monthly Contribution:			
Salary Tier 1 (< $42,024)	$122	$98	$288
Salary Tier 2 ($42,024 - $63,036)	$150	$125	$300
Salary Tier 3 (> $63,036)	$186	$161	$300
Employee + 1 Coverage			
Total Monthly Premium	**$1,362**	**$1,270**	
Employee Monthly Contribution:			
Salary Tier 1 (< $42,024)	$310	$266	$528
Salary Tier 2 ($42,024 - $63,036)	$446	$402	$528
Salary Tier 3 (> $63,036)	$565	$521	$528
Family Coverage			
Total Monthly Premium	**$1,903**	**$1,764**	
Employee Monthly Contribution:			
Salary Tier 1 (< $42,024)	$393	$322	$852
Salary Tier 2 ($42,024 - $63,036)	$546	$475	$852
Salary Tier 3 (> $63,036)	$691	$620	$852

- 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 spouse with the higher salary tier

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.

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.

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.)*

Luther College Contributions to Health Savings Accounts: If you enroll in the HDHP option for 2025 and meet the criteria to contribute to an HSA, Luther will make a College funded contribution to your HSA:

HDHP Enrollment Tier	College HSA Contribution (Annual)	2025 IRS Maximum Contribution
Single	$300	$4,300
Employee + 1	$600	$8,550
Family	$900	$8,550

Please note that HSA contributions are available only for current Luther College employees, not for emeriti, staff retirees, or their spouses.

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 2025 limits are as follows:
    - $4,300 for individual coverage
    - $8,550 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 2024 and are choosing to elect the HDHP option for 2025, you MUST have a zero balance in your Health Care FSA as of December 31, 2024 to be eligible to contribute your own money to the Health Savings Account (HSA) on January 1, 2025; if your balance in the FSA is not $0 on January 1, 2025, you may not contribute to your HSA until April 1, 2025.

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. 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.

Note: Remember, in order to receive reimbursements from your FSAs in 2025, 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 $3,300 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 $3,300 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, 2025 with a grace period through March 15, 2026 which is the date you must **incur** any eligible claims. Please plan your contributions carefully. Any money remaining in your account after March 31, 2026 (the date in which you have to submit for claims incurred 1/1/25 – 3/15/26) will be forfeited. This is known as the “use it or lose it” rule and it is governed by IRS regulations.

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 fees for Teladoc of $75 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 include cold and flu symptoms, upper respiratory infections, allergies, children’s health issues, aches and pains, wellness, medication advice, and advice for family members.

Other services available through Teladoc:

- Dermatology: $85/visit ($20 copay on PPO plan)
- Psychiatrist (Initial): $235/visit
- Psychiatrist (Ongoing): $105/visit

EyeMed Vision Discount Program *(all employees)*

Delta Dental has teamed up with EyeMed Vision Care as your source for quality eye care services; you do not need to be enrolled in Dental to access this. Your vision plan provides you with the choice and service you expect - all at a great value. Your discount plan is unlimited and provides:

- Great overall savings up to 35%
- Access to thousands of private practice and retail providers nationwide including, LensCrafters, Target Optical, and most Pearle Vision locations
- Choice of any product, including designer brand name frames
- Savings on laser vision correction
- Ability to order contact lenses online using your benefit

Visit eyemevisioncare.com/deltadental to learn more or find a provider hear you.

Amplifon Hearing Discount Program *(all employees)*

Do you often find yourself asking others to repeat themselves? Is there a constant ringing in your ears? If so, your ears could be trying to tell you something. If you think you may have hearing loss, don't worry. Delta Dental of Iowa has teamed up with Amplifon to offer you quality hearing care; you do not need to be enrolled in Dental to access this. Call 866-925-1698 or visit deltadentalia.com/hearing to learn more.

- Up to $125 off a hearing exam
- Up to $2,995 off per hearing device – includes all major brands and technology levels
- 1 year of free follow-up care
- Free batteries for 2 years
- 3-year warranty for loss, repairs or damage

UnitedHealthcare Hearing *(employees on health plan only)*

Take charge of your hearing health today
Treating hearing loss may help you rediscover parts of your life that you may have felt missing – including engaging in daily activities and staying connected to the people you love. You'll also support your long-term health.

Through UnitedHealthcare Hearing, you'll save up to 50% a wide selection of hearing aids and services.

1. **Contact UnitedHealthcare Hearing to schedule an initial hearing exam and consultation – 866-926-6632**
2. **Your provider will help you find the perfect Solution –** At your consultation and exam, your provider will assess your hearing and provide a personalized recommendation. Plus, they'll be able to answer any questions you have.

- You have 60 days to try out hearing aids purchased from a provider
- Your plan includes a three-year extended warranty for repairs and a one-time loss or damage replacement.
- Schedule up to three follow-up visits at no cost, with additional support available
- Receive a no-cost hearing exam
- Choose from high-quality hearing aids including Relate, Beltone, Oticon, Phonax, ReSound, Unitron, Signia, Widex and Starkey

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	\$39 \$84
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 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.

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 Basic Life and AD&D Insurance and Accidental Death Insurance to all eligible employees at no cost to you.

	Life Insurance	Accidental Death Insurance
Age < 65	2x annual salary	2x annual salary
Age 65 – 69	1.34x annual salary	1.34x annual salary
Age > 70	Annual salary	Annual salary
Maximum Amount	$275,000	$275,000

The portion of the premium paid for life insurance coverage over $50,000 will, as required by the IRS, be treated as taxable income.

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, subject to UNUM accepting your 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 RxHelp@rxbenefits.com
Dental Plan	Delta Dental of IA	92348	800-544-0718	www.deltadentalia.org
Health Savings Account (HSA)	Optum Bank	N/A	866-234-8913	www.optumbank.com
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	medservices@assistamerica.com
Amplifon Hearing Discount Program	Thru Delta Dental of IA	N/A	866-925-1698	www.deltadentalia.com/hearing
EyeMed Vision Discount Program	Thru Delta Dental of IA	N/A	866-246-9041	www.eyemevisioncare.com/deltadental
Life, Voluntary Life, and LTD Insurance	UNUM	691293 691294 335731	866-679-3054	http://www.unum.com
403(b) Retirement Plan	TIAA	103157	1-800-842-2776	http://www.tiaa.org/luther
Retirement Plan Advisors	Millennium Advisory Services	N/A	877-435-2489	schedule@mcmva.com
Open Enrollment	Luther College Human Resources	N/A	563-387-1134	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.

Luther College's Health and Welfare Benefits Annual Notice Packet

For the 2025 Plan Year,

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact Human Resources.

Medicare Part D

Creditable Coverage Notice

Important Notice from Luther College
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Luther College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan while enrolled in Luther College coverage as an active employee, please note that your Luther College coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Luther College coverage as a former employee.

You may also choose to drop your Luther College coverage. If you do decide to join a Medicare drug plan and drop your current Luther College coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Luther College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Luther College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

3. Visit www.medicare.gov
4. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
5. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Luther College group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

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 sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Luther College, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Luther College, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Luther College HIPAA Privacy Officer.

Effective Date

This Notice as revised is October 20, 2024

Our Responsibilities

We are required by law to:

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

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

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

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

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the

treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

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

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

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

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

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

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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

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

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

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

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

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

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

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

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

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

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

Research
We may disclose your protected health information to researchers when:

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

Required Disclosures

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

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

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

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

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

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

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

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

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable

fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

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

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

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visitinghttps://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html .

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 July 31, 2024, 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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about 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.