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Group Health Insurance Benefits Guide 2023

Medical Plan Comparison

2023

	GOLD PPO PLAN	HIGH PLAN W/ HSA	LOW PLAN W/ HSA
In-Network Services			
Deductible Individual/Family	$5,000 / $10,000	$5,500 / $11,000	$5,500 / $11,000
Out-of-Pocket Max Individual/Family	$8,000 / $16,000	$7,500 / $15,000	$7,500 / $15,000
Coinsurance	Plan pays 80%	Plan pays 100%	Plan pays 100%
Office Visit	$25 copay	$35 / $55 copay after deductible	$35 copay after deductible
Specialist Visit	$50 copay	$50 / $75 copay after deductible	$50 copay after deductible
Imaging / Diagnostic Test	Office: Physician Copay Other: Subject to ded. + 20%	Subject to deductible	Subject to deductible
Inpatient Hospital/ Outpatient Surgery	Subject to deductible + 20%	Subject to deductible	Subject to deductible
Emergency Room	$450 copay after deducible	$450 copay after deductible	$450 copay after deductible
Urgent Care	$100 copay	$100 copay after deductible	$100 copay after deductible
Prescription Drugs • Tiers 1/2/3/4 • Mail Order	No deductible $20/$40/$70/20% to $500 $40/$100/$190/ N/A	Subject to deductible then $20/$40/$70/10% to $350 $45/$105/$195/ N/A	Subject to deductible then $20/$40/$70/10% to $350 $45/$105/$195/ N/A
HSA/FSA Eligibility	FSA	HSA / LP FSA	HSA / LP FSA
Employee Rates per Pay Period			
Employee Only	$280.91	$179.51	$112.90
Employee + Spouse	$805.57	$469.03	$431.69
Employee + Child/ren	$728.76	$465.71	$439.34
Employee + Family	$825.08	$539.52	$508.98

In-network services illustrated only. Refer to ADP for the full plan documents.
Local Plus network utilizes Piedmont facilities and physicians ONLY.

HEALTH PLAN TERMINOLOGY

Annual Limit	Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
Claim	A bill for medical services rendered.
Cost Sharing	Health Care Provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
Coinsurance	Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service. Example: Ann's surgery cost is $7,000. She has a $2,000 annual deductible. Ann is responsible for the first $2,000 of allowed charges, and that amount is applied to the deductible. The carrier will cover 80% (coinsurance) of the remaining $5,000 and Ann will cover 20% or $1,000. The total member out of pocket expense for Ann's surgery is $3,000 (the deductible of $2,000 + coinsurance of $1,000).
Copayment (Copay)	A fixed amount you pay for a covered heath care service, usually when you receive the service. Copays often apply to office visits, emergency room visits, and prescription drugs.
Deductible	The amount you owe for covered health care services each year before the insurance company begins to pay. (For some services you would pay a copay in lieu of the deductible as noted above.) Example: John has a health plan with a $2,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $1,500. Because John hasn't paid anything toward his deductible yet this year, the $1,500 surgery cost goes towards the deductible and John is responsible for 100% of this cost.
Dependent Coverage	Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage apply to dependent children (usually covered to age 26).
Explanation of Benefits (EOB)	A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
Group Health Plan	A health insurance plan that provides benefits for employees of a business.
In-Patient Care	Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
Insurer (Carrier)	The insurance company providing coverage.
Insured	The person with health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
Open Enrollment Period	The time period during which eligible persons may opt to sign up for coverage under a group health plan or make changes to who is covered under the plan.
Out-of-Pocket Maximum (OPM)	The maximum amount you should have to pay for your health care during one year, excluding monthly premium. After you reach the annual OPM, your health insurance plan begins to pay 100% of the allowed amount for covered health care services or items for the rest of the plan year.
Outpatient Care	Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or less
Participating Provider	A health care provider who has contracted with a particular insurance carrier or health plan to provide health care services to its members. Also known as in-network provider.
Premium	Amount of money charged by an insurance company for coverage
Preventive Care	Medical check-ups and tests, immunizations and other services used to prevent chronic illnesses from occurring.
Primary Care Physician (PCP)	A physician (family doctor/pediatrician, OB-GYN, etc.) who is responsible for monitoring and coordinating a member's overall care. Some managed care plans require the member to select a PCP when they enroll for coverage.
Provider	A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
Qualifying Life Event	A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, having or adopting a child, and losing coverage elsewhere.
Qualified Medical Expense	Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.
Summary of Benefits & Coverages (SBC)	An easy-to-read outline that lets you compare costs and coverage between health plans.
Telemedicine	A form of technology based communication that allows a doctor and patient to communicate without being in the same physical location. This can be used to evaluate, diagnose and prescribe treatment for common illnesses in lieu of an office visit or urgent care visit.
Utilization	The extent to which a particular group uses a particular health plan or program.

INTEGRATED source one

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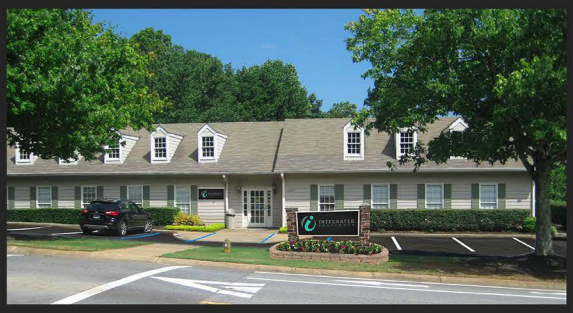
Employee Health Center

Powered by Integrated Source One



The ISO Onsite Difference

	ISO Clinic	Primary Care Network Model*
Services	80-90% of primary care, multidisciplinary, acute care, lab testing, preventative care	Traditional Primary Care
Appointment Times	Same Day often Same Hour	Average 23 days
New Patients	Yes	No/Maybe
Wait time in Waiting Room	< 2 Minutes	22 Minutes
Patients Seen In A Day	7 – 10 average visit time 20 - 30 minutes	30-45 average visit time 7 minutes
Onsite Labs	Yes	Maybe
Visit patient payment out-of-pocket	Zero	Yes Copay & Deductible
Labs, MRI, CT Other Imaging, Special Consults	Zero Copays Zero Deductibles (Exemplar can waive Patient's Responsibility)	Yes Copay & Deductible

*National average Primary Care Networks

Carrier Contact Information

VENDOR	PURPOSE	PHONE	EMAIL/WEB
Exemplar Health Benefits	- Member Services - Claims Administration - Compliance	(855) 826-3422 M-F 8:00 – 5:00 EST	Member.services@exemplarhba.com
First Health	PPO Network – Contact Exemplar Or North Risk Partners for In-Network Providers	(888) 246-9949 M-F 8:00 - 8:00 Est.	https://www.providerlocator.firsthealth.com/LocateProvider/SelectNetworkType
Pro Rx Solutions	Pharmacy Benefit Manager (PBM)	(833) 656-1509 M-F 8:00 - 8:00 EST	https://www.prorxsulutions.com/
Integrated Source One	- Free Direct Primary Care - Health Care Navigation	(866) 969-4761 Hours – Virtual 24/7 Onsite - 8 – 6 EST	https://www.intsourceone.com

Eligibility & Enrollment

Who Is Eligible

If you're a full-time employee you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. Coverage is effective 1st of the month following the completion of 30 days of employment. In addition, the following family members are eligible for group health insurance coverage:

- Spouse
- Children under the age of 26 (some exclusions)

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. For additional information, please feel free to contact Life University's Human Resource department.

When to Enroll

Our Open Enrollment Period begins a couple months prior to our effective date and may vary from year to year. It is very important for Life University to give all employees ample time to make benefit decisions every year prior to our effective date of January 1st.

How to Make Changes After Open Enrollment

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

For additional information please feel free to contact Life Universities human resource department.

MARKETPLACE NOTICE

NOTICE TO NEW HIRES!

New Health Insurance Marketplace Coverage Options and Your Health Coverage

As of January 2014, health insurance can be purchased through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.) **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer sponsored plan's administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

NO SURPRISE BILLING ACT

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. **"Out-of-network"** describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. **"Surprise billing"** is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency Services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing.

You also aren't required to get care out-of-network.

You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your plan's administrator or the U.S. Department of Health and Human Services for guidance.

Visit www.hhs.gov for more information about your rights under federal law.

Visit https://www.legis.iowa.gov/docs/publications/BF/1069201.pdf for more information about your rights under Iowa Laws.

PATIENT RIGHTS NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

For information regarding your rights and our responsibilities regarding how your medical information may be used and disclosed under the Health Insurance Portability & Accountability Act and how you can get access to this information, view the notice provided by your medical carrier or visit the Health and Human Services Website at www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment 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 you 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. To request special enrollment or obtain more information, contact your Employer Representative.

PATIENT PROTECTION CHOICE OF PROVIDERS

In cases where your employer's group health plan allows or requires a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, your employer or health plan carrier may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your employer sponsored plan's administrator. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology contact your employer sponsored plan's administrator.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance insurers 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 a 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 if applicable). In any case, plans and insurers 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- 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.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication **Your Rights After A Mastectomy**.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication **Compliance Assistance Guide – Health Benefits Coverage Under Federal Law**.

SPECIAL ENROLLMENT PERIODS

NOTICE TO ALL EMPLOYEES

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your plan's administrator.

COBRA NOTICE
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 [*choose and enter appropriate information:* must pay *or* aren't required to 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."

The following applies only to retiree health plan offerings:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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; *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Continuation Coverage Rights Under COBRA

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 [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

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. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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 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. https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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/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.

CHIPRA NOTICE

Premium Assistance Under Medicaid & Children's Health Insurance Program

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).

You may be eligible for assistance paying your employer health plan premiums, policies differ by state. The following list of states is current as of January 31, 2022. Contact your state's agency for more information on eligibility:

Iowa – Medicaid and CHIP (Hawki)

Medicaid:	Website:	https://dhs.iowa.gov/ime/members	Phone:	1-800-338-8366
Hawk-i:	Website:	http://dhs.iowa.gov/Hawki	Phone:	1-800-257-8563
HIPP	Website:	https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Phone:	1-888-346-9562

Minnesota - Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-services/other-insurance.jsp

Phone: 1-800-657-3739

Nebraska Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633 - Lincoln: 402-473-7000 - Omaha: 402-595-1178

South Dakota – Medicaid

Website: http://dss.sd.gov Phone: 1-888-828-0059

All Other States

To view additional states that are not listed here, or check for changes, visit the full list on the Department of Labor's website at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

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

MEDICARE PART D
Notice of Creditable Coverage

Important Notice regarding your prescription drug coverage and Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lifecare University 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. Life University has determined that the prescription drug coverage offered by Excel Health Plans 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, your current EHBA coverage with Life University will not be affected. If you decide to join a Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will be able to get this coverage back after an event.

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 Life University 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…

You may 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 Excel 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:

- Visit www.medicare.gov
- 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
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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).

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This guide contains tables that summarize certain provisions of the carrier plan(s) illustrated. Complete plan information is included in the legal documents and brochures that govern each plan, these documents are available upon request. If there is a difference between this handout and the legal documents, then the legal documents will govern.