

2026 EMPLOYEE BENEFITS GUIDE



Benefits

DESIGNED FOR YOU

Your benefits are an important part of your total compensation package.

Please take the time to review this Benefits Guide to assist you in making informed enrollment decisions that are the best fit for the health, wellness and financial needs of you and your family.

VIEW YOUR ADP BENEFITS HUB

On the Benefits Hub you will find everything you need to make informed decisions about your benefits.

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IMPORTANT CONTACTS



REMINDER! You can contact Hylant Advocacy to help with claims, benefits questions, and more!

Phone: (833) 690-7730 or Email: benefithelpNE@hylant.com.



Questions About	Contact	Phone	Website / Email
Medical	Anthem	(833) 952-2042	www.Anthem.com
Prescription Drug	Anthem	(833) 952-2042	www.Anthem.com
Wellness	WellWorks	(800) 425-4657	www.wellworksforyou.com
Voluntary Dental	Unum	(866) 679-3054	www.unumdentalcare.com
Voluntary Vision	Unum	(866) 679-3054	www.unumvisioncare.com
Health Savings Account	HealthEquity	(866) 346-5800	www.healthequity.com
Life & Disability	Unum	(866) 679-3054	www.unum.com/employees
Critical Illness, Hospital Indemnity, Accident	Unum	(866) 679-3054	www.unum.com/employees
Employee Assistance Program	Unum	(800) 854-1446	www.unum.com/lifebalance

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 46 for more details.

HYLANT MEMBER ADVOCACY

EMPLOYEE BENEFITS

Hylant has a team of client service professionals available to assist employees and their families with their healthcare benefits.

Provide benefit plan education

- How does my insurance work
- Differences in the benefit options available

Provide understanding on cost sharing requirements

- Deductibles
- Coinsurance/Copayment
- In-Network vs Out-of-Network

Provide guidance on covered procedures

- Verify coverage of services
- Explain pre-authorization requirements
- Advise on covered service maximums

Liaison between employee, providers, and insurance carrier

- Identify billing/coding discrepancies
- Work with providers and insurance carriers to resolve escalated billing issues
- Assist with claims appeals and grievances
- Assist with out-of-network claims reimbursement

Assist with carrier on-line navigation

- Member Registration
- Provider/Facility search
- Prescription and medical cost comparisons

Assist with life and disability benefits

- Provide explanation of how benefits work
- Provide necessary forms for filing a claim
- Submit claims to the carrier and follow up on progress

Other Services

- Order ID cards
- Order carrier materials



Hylant Client Service Professionals
are available from 8:00 a.m. to 4:30 p.m. EST Monday through
Friday at (833) 690-7730 or benefithelpNE@hylant.com.

All communications are kept private and confidential.

WHAT'S CHANGED IN 2026!

- A Spousal Surcharge has been added to the benefits. A \$150 surcharge will be applied for spouses who are eligible for coverage through the spouse's own employer (*See page 5 for details*).
- The Individual / Family Deductibles are increasing to \$3,400 / \$6,800 to comply with 2026 IRS guidelines.
- Unum is the new insurance carrier for the following benefits:
 - Dental
 - Vision
 - Life/AD&D
 - Voluntary Life
 - Disability
 - Worksite Benefits (Accident, Critical Illness, & Hospital Indemnity)



Questions About Your Benefits?

Contact your Human Resources Department

ELIGIBILITY

Employees who are regularly scheduled to work 30 or more hours in a week are considered full-time and are eligible for benefits at Heidelberg University. Changes to benefits are only allowed during open enrollment unless you have a qualifying life event.



COVERAGE BEGINS: For those who enroll, coverage begins on the first day of employment.

COVERAGE ENDS: If employment is terminated, coverage ends on the last day of the month.



ELIGIBLE DEPENDENTS



SUBMITTING PROOF *If requested*



SPOUSAL SURCHARGE



Your **spouse/domestic partner**



Your children from birth to age 26*

- ✓ Birth Certificate
- ✓ Social Security Card
- ✓ Marriage License
- ✓ Legal Documents
- ✓ Adoption Certificate
- ✓ Proof of 1+ year cohabitation for Domestic Partners

A \$150 surcharge will be applied for spouses who are eligible for coverage through the spouse's own employer

MAKING CHANGES DURING THE YEAR

Due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment.

The only exception is if you have a qualifying life event. In most cases, changes must match the event and be requested within **30 days**. Qualifying events include, but aren't limited to:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Death of a dependent
- Change in your spouse's employment status
- Change in coverage under your spouse's plan
- A loss of eligibility for other health coverage
- Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) (60 days)
- Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP (60 days)

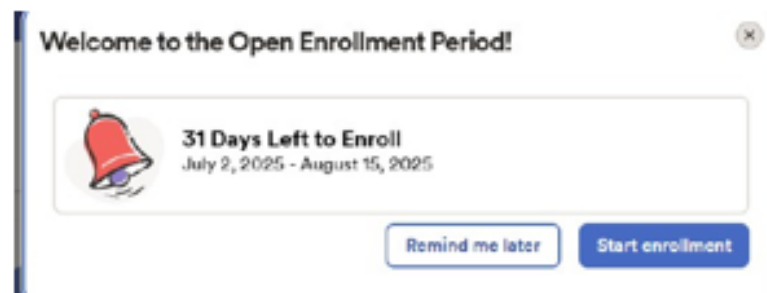


HOW TO ENROLL

All employees who are eligible for benefits MUST complete an open enrollment during the month of May 2026, even if you do not want to make any changes and even if you were just hired. **All changes will be effective July 1, 2026.**

ON YOUR COMPUTER

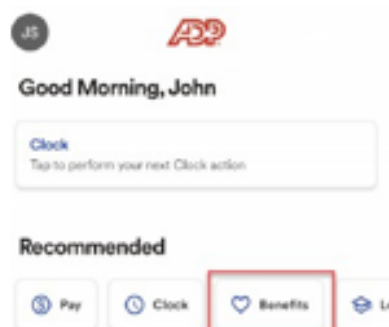
1. Log in to Workforce Now to access the Employee Self-Service website: <https://workforcenow.adp.com>.
Upon logging in, you will be presented with a pop up or a task showing important information about this Open Enrollment period. This will be displayed each time you log in during the open enrollment period until you have completed your selections.



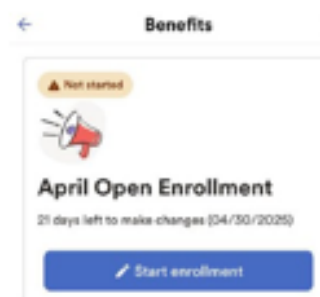
2. Selecting "**Start enrollment**" will bring you to the Myself->Benefits->Enrollments screen where you can click "**Start enrollment.**"

ON YOUR MOBILE APP

1. If you are using the mobile app, after logging in you will be see recommended tiles. **Click on Benefits.**



2. To start your enrollment, click **Start enrollment.**



Note: If you have never logged into ADP before, please contact HR.

Bi-Weekly Cost of Coverage

	BI-WEEKLY CONTRIBUTIONS			
	Employee	Employee + Spouse	Employee + Child(ren)	Family
Medical				
< \$28,500	\$59.49	\$121.92	\$104.90	\$178.68
\$25,501 - \$47,499	\$77.79	\$159.44	\$137.17	\$233.66
\$47,500 - \$75,000	\$96.10	\$196.95	\$169.45	\$288.64
> \$75,000	\$114.40	\$234.47	\$201.72	\$343.62
Voluntary Dental				
Low Plan	\$12.18	\$24.36	\$31.06	\$43.24
High Plan	\$15.40	\$30.80	\$39.27	\$54.68
Voluntary Vision				
Core Plan	\$3.10	\$6.20	\$6.97	\$10.88

**Rates do not include Spousal Surcharge*

Rates for voluntary coverages are included in the enrollment system.

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan lets you pay for benefits like medical, dental, and vision with pre-tax dollars, reducing taxable income. Elections are locked in for the 12-month plan year unless a qualifying life event occurs.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

IMPUTED INCOME

In certain situations, the value of employer-paid coverage will be added to your gross income, and you will pay taxes on it. This could apply if you are covering someone who isn't your legal spouse or dependent (defined by IRS) or your employer provides greater than \$50,000 in life insurance.

Monthly Cost of Coverage

	MONTHLY CONTRIBUTIONS			
	Employee	Employee + Spouse	Employee + Child(ren)	Family
Medical				
< \$28,500	\$128.89	\$264.17	\$227.27	\$387.14
\$25,501 - \$47,499	\$168.55	\$345.45	\$297.20	\$506.26
\$47,500 - \$75,000	\$208.21	\$426.73	\$367.13	\$625.38
> \$75,000	\$247.87	\$508.01	\$437.06	\$744.50
Voluntary Dental				
Low Plan	\$26.19	\$52.35	\$66.75	\$92.93
High Plan	\$33.37	\$66.73	\$85.09	\$118.47
Voluntary Vision				
Core Plan	\$6.72	\$13.43	\$15.10	\$23.57

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INFO TO KNOW



	PREVENTIVE CARE	DIAGNOSTIC CARE
WHAT IT MEANS:	For when nothing's wrong and you feel fine.	You have a symptom, or you have a known health issue.
WHAT YOU PAY:	You won't pay anything.	This is a diagnostic claim. Deductible, copays, and coinsurance apply.



IN-NETWORK: These are doctors, hospitals, and clinics that have an agreement with your insurance company, to offer services at lower preset prices.



OUT-OF-NETWORK: These are doctors, hospitals, and clinics that don't have an agreement with your insurance company, so they can charge you the full price for their services.

What the terms mean...

100%
coverage for
preventive care

Annual Deductible — The amount you pay before insurance pays.

Coinsurance — After the deductible has been met, you and the plan will split the cost of claims.

Out-of-Pocket Maximum — The maximum you will pay in the calendar year. Once you meet the OOP max, the plan pays 100% of eligible claims for the remainder of the year.

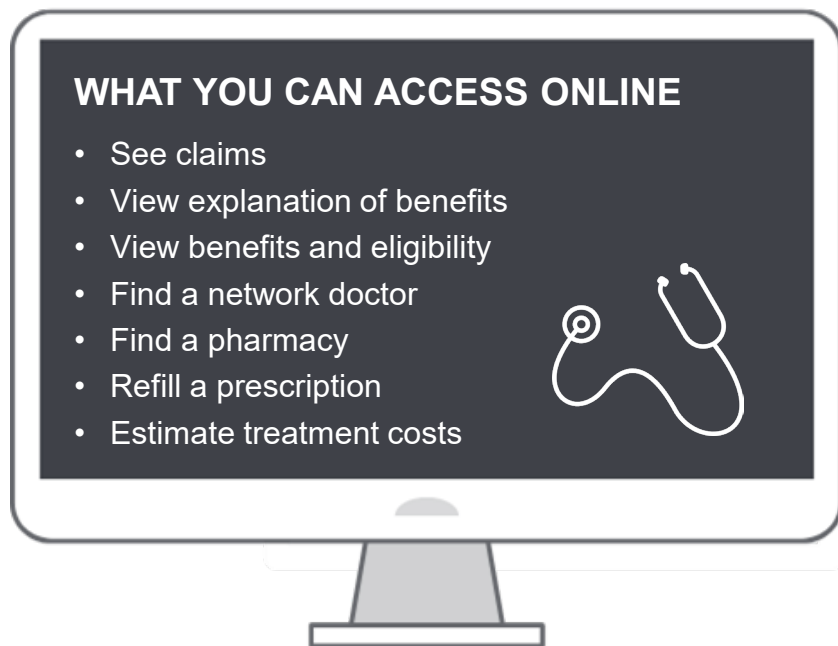
Copayment — The fixed amount you pay for common services.

MEDICAL COVERAGE

	HDHP Plan
Network	In-Network
DEDUCTIBLE	
Individual	\$3,400
Family	\$6,800
COINSURANCE	
Plan Pays	100%
You Pay	0%
OUT OF POCKET MAXIMUM	
Individual	\$4,050
Family	\$4,500
COMMONLY USED SERVICES	
Primary Care Physician Visit	100% after deductible
Specialist (SPC) Visit	100% after deductible
Virtual Visit	100% after deductible
Preventive Care Services	100% coverage
Urgent Care Visit	100% after deductible
Emergency Room Visit	100% after deductible
Diagnostic Lab & Imaging	100% after deductible
Complex Imaging (MRI, CT)	100% after deductible
Outpatient Surgery	100% after deductible
Hospitalization	100% after deductible
PRESCRIPTION DRUG	
Tier 1 – Generic	\$5 copay after deductible
Tier 2 – Formulary	\$20 copay after deductible
Tier 3 – Non-Formulary	\$40 after deductible
Specialty	20% to a max of \$150 copay after deductible
Mail Order	Available at 2 times copay
OUT-OF-NETWORK	
Medical	Available at a higher cost share
Pharmacy	Available at a higher cost share

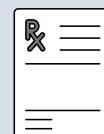
MEMBER TOOLS


Anthem provides online resources to help you make well-informed choices for care and make best use of your health care dollars. Our easy, handy tools let you find a new doctor, compare health care costs and more.




CREATE YOUR MEMBER ACCOUNT

- Visit www.anthem.com and click **Log In**
- Click **Register Now**
- Complete required information to register (First & Last name and Date of Birth)
- Follow the remaining prompts to create your member account

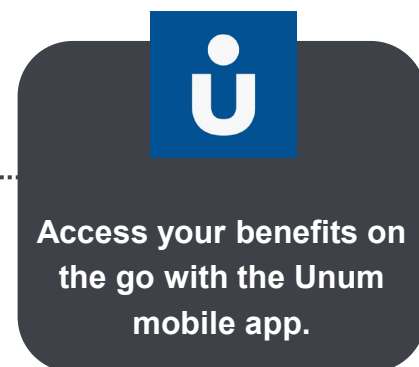
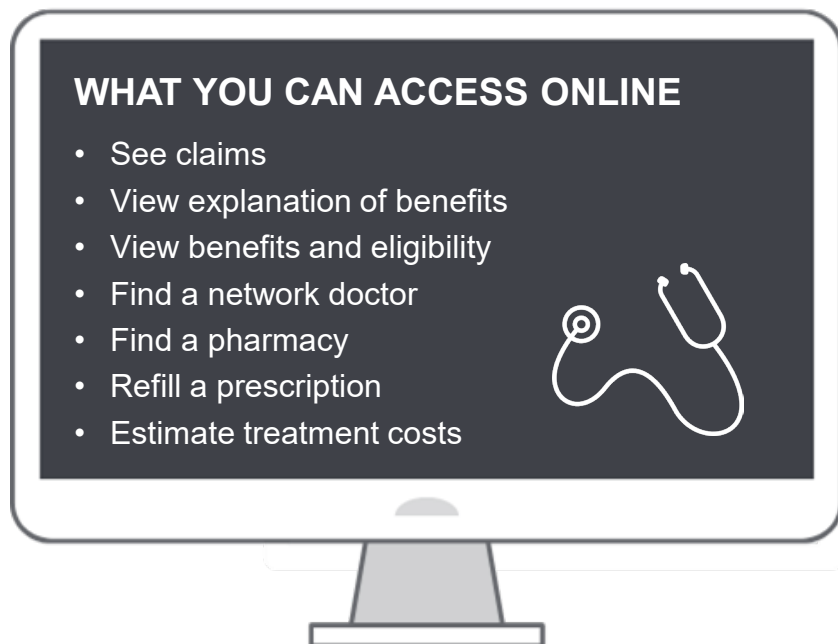


 www.anthem.com

 (844) 912-0938

MEMBER TOOLS

Unum provides online resources to help you make well-informed choices for care and make best use of your health care dollars. Our easy, handy tools let you find a new doctor, compare health care costs and more.



CREATE YOUR MEMBER ACCOUNT

- Visit www.unum.com and click **Log In**
- Click **Create an Account** & then select **Register as a Policyholder or Employee**
- Complete required information to register
- Follow the remaining prompts to create your member account



www.unum.com



(866) 679-3054

TELEMEDICINE

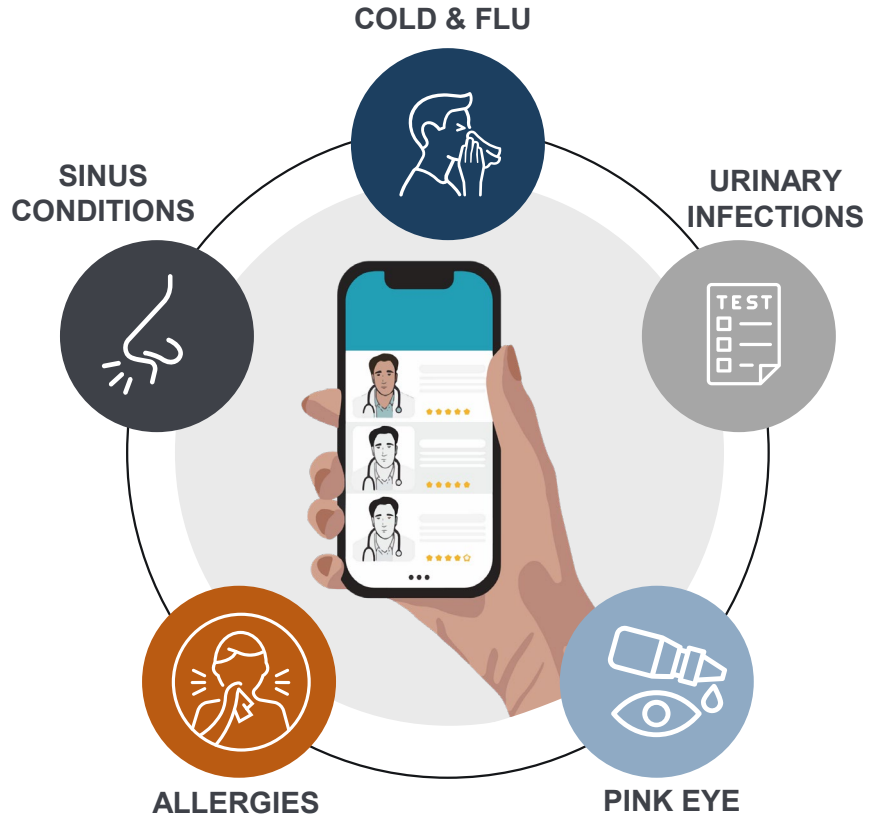


NOT ALL VIRTUAL DOCTOR'S VISITS ARE TELEMEDICINE

Be sure to use Live Health Online for a lower cost share.

When to use Live Health Online via Sydney App

- ✓ On a vacation or business trip
- ✓ After business hours or weekend
- ✓ For non-emergent care
- ✓ If your Primary Care Physician is unavailable
- ✓ For a short-term Rx refill






COST OF CARE



	Primary Care / Mental Health	Specialist
HDHP-HSA Plan	100% After Deductible	100% After Deductible

CONTACT

-  www.livehealthonline.com
-  (888) 548-3432
-  Download the Sydney App to access telemedicine



KNOW WHERE TO GO



TELEMEDICINE

Telemedicine is a good alternative when your own doctor is not available, or when you need non-urgent medical care.

- Cold or flu symptoms
- Bladder infections
- Rashes
- Sinus problems
- And more

WHAT IT COSTS

\$



DOCTOR'S OFFICE

If your symptoms **aren't urgent**, make an appointment with your regular doctor to discuss your health issue.

Remember, you may be able to have a video or telephone visit with your doctor instead of going in-person.

WHAT IT COSTS

\$\$



URGENT CARE

Urgent Care centers can treat moderate medical concerns, such as:

- Sprains, minor wounds, broken bones
- Severe cold or flu symptoms

WHAT IT COSTS

\$\$\$



EMERGENCY CARE

Go to the ER if you're experiencing a true emergency where immediate medical care is needed such as*:

- Chest pain, large wounds, broken bones

WHAT IT COSTS

\$\$\$\$

**call 911 if your health issue is life-threatening*

DENTAL COVERAGE



BALANCE BILLING: If you use an out-of-network provider, you will be charged the difference between what they billed and what your insurance allows. For example, if the charge is \$100 and your insurance covers \$70, you might get a bill for the remaining \$30.

	Low Plan	High Plan
Network	Unum	Unum
DEDUCTIBLE	Calendar Year	Calendar Year
Individual	\$50	\$50
Family	\$150	\$150
COVERED SERVICES		
Type I - Preventive	100%	100%
You Pay	0%	0%
Type II - Basic	80%	90%
You Pay	20%	10%
Type III - Major	50%	60%
You Pay	50%	40%
BENEFIT MAXIMUM		
Annual Limit per Covered Person	\$1,000	\$1,000
Services Counted Toward Max	Type II, Type III	Type II, Type III
OUT-OF-NETWORK		
Out-of-Network Claims	Included at the same cost share, but balance billing may apply	Included at the same cost share, but balance billing may apply

See the [contacts page](#) for where to find providers.



Unum Dental™

Dental Insurance can help you pay for dental exams, cleanings and other services.

How does it work?

Good dental care is critical to your overall well-being. With Unum Dental insurance, you can get the attention your teeth need — at a cost you can afford.

Unum Dental allows you to see any dentist you choose.

To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to file your claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.



Why is this coverage so valuable?

- ✓ Routine dental care keeps your mouth and whole body healthy.
- ✓ Your plan is backed by Unum’s commitment to excellence in customer service.
- ✓ Personalized website to manage your benefits including claims information, ID cards and more.
- ✓ There’s no waiting period for preventive and basic services.

What else is included?

Pregnancy benefit

An extra cleaning for expecting mothers in their 2nd or 3rd trimester.

Wellness benefits

Oral cancer screenings for patients 40 and older with high risk factors.

Unumdentalcare.com

Use unumdentalcare.com to search for providers, manage your benefits and learn about good dental health. Features include easy access to ID Cards, claims history and coverage information.

Virtual Dental Visits

24/7 dental care for dental emergencies when an in-person visit isn’t an option. Available for active dental members*.

Visit unumdentalcare.com and click Virtual Dental Visits to get started.

*Virtual dental visits are a preventive service and subject to policy year benefit maximum.

Covered Procedures & Waiting Periods	Active PPO	Active PPO
CLASS A PREVENTIVE SERVICES	Waiting Period: None <ul style="list-style-type: none"> • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) <ul style="list-style-type: none"> – (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers • Full mouth/panoramic x-rays (1 per 36 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+) 	Waiting Period: None <ul style="list-style-type: none"> • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) <ul style="list-style-type: none"> – (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers • Full mouth/panoramic x-rays (1 per 36 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+)
CLASS B BASIC SERVICES	Waiting Period: None <ul style="list-style-type: none"> • Emergency Treatment (1 per 12 months) • Simple restorative services (fillings) <ul style="list-style-type: none"> – Posterior composite restorations • Simple extractions • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture or bridge 	Waiting Period: None <ul style="list-style-type: none"> • Emergency Treatment (1 per 12 months) • Simple restorative services (fillings; Benefit allowed for amalgam restorations on posterior teeth) • Simple extractions • Oral Surgery (extractions and impacted teeth)
CLASS C MAJOR SERVICES	Waiting Period: None <ul style="list-style-type: none"> • Inlays and onlays • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Periodontal maintenance (2 per 12 month in combination with prophylaxis) • Endodontics (root canals) • Crowns, bridges, dentures and implants 	Waiting Period: None <ul style="list-style-type: none"> • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture or bridge • Inlays and onlays • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Periodontal maintenance (2 per 12 month in combination with prophylaxis) • Endodontics (root canals) • Crowns, bridges, dentures and implants

Refer to your certificate of coverage for the services covered under your plan.

VISION COVERAGE



WHEN CAN YOU GO? Your vision coverage allows you to get an eye exam and new glasses or contact lenses every calendar year. Make sure to use your benefits to keep your eyes healthy.



	Unum Vision Core Plan
Network	EyeMed
COPAYS	
Exam	\$10 copay
Materials	\$25 copay
COVERED SERVICES	
Frames	
Maximum Allowance	\$150 allowance
Frequency	Every 24 months
Lenses (<i>instead of contacts</i>)	
Single / Bifocal / Trifocal	Covered in full after \$25 copay
Basic Progressive	Additional \$65 copay
Other lens enhancements	Discounts May Apply
Frequency	Every 12 months
Elective Contact Lenses (<i>instead of lenses</i>)	\$150 allowance
Frequency	Every 12 months
OUT-OF-NETWORK	
Out-of-Network Claims	Available at a higher cost share

See the [contacts page](#) for where to find providers.

Unum Vision Powered by EyeMed



Plan features:

Members have the freedom to choose any provider from EyeMed's Insight Network. Our network offers the right mix of independent, national retail and regional retail providers like Lens Crafters, Pearle Vision, Target Optical and many more. Members can also purchase glasses and contact lenses online at [Glasses.com](https://www.glasses.com) and [ContactsDirect.com](https://www.contactsdirect.com).

Covered benefits:

Exam: Each member is entitled to a comprehensive vision exam. An exam co-pay applies and is outlined in the grid at right.

Materials: Each member has coverage for covered services and materials. Purchases are subject to benefit frequencies and co-pays. Plan features include:

- **Frame benefit:** You may choose any frame within a provider's collection, subject to the retail frame allowance listed at right. If the cost is greater than the plan's benefits, you are responsible for the difference.
- **Eyeglass lens benefit:** Standard plastic (CR-39 Plastic Material) single vision, bifocal, trifocal, and specialty lenses are generally covered after any applicable materials copay. If covered by plan allowance, you are responsible for any cost greater than the plan's benefit.
- **Contact lens benefit:** Members electing contact lenses instead of eye glass lenses may apply the contact lens allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, you are responsible for the difference.

Laser vision correction: Discounts are available with participating surgery providers across the country (not an insured benefit)

EyeMed benefits:

Vision Care Services	In-network Member Cost	Out-of-network Reimbursements
Exam (1 per 12 months)	\$10 co-pay	Up to \$40
Retinal Imaging Benefit	Up to \$39	Not covered
Standard Plastic Lenses (1 per 12 months)		
Single Vision	\$25 co-pay	Up to \$30
Bifocal	\$25 co-pay	Up to \$50
Trifocal	\$25 co-pay	Up to \$70
Lenticular	\$25 co-pay	Up to \$70
Standard Progressive	\$90 co-pay	Up to \$50
Premium Progressive Lens		
Premium Progressive Tier 1	\$110 co-pay	Up to \$50
Premium Progressive Tier 2	\$120 co-pay	Up to \$50
Premium Progressive Tier 3	\$135 co-pay	Up to \$50
Premium Progressive Tier 4	\$90 co-pay (80% of charge less than \$120 allowance)	Up to \$50
Lens Options		
Polycarbonate Lenses (under age 19)	Covered	Up to \$32
Frames (1 per 24 months) Members may select any frame available	\$150 allowance	Up to \$105
Contact Lenses (1 per 12 months) In lieu of eyeglass lenses		
Elective	\$150 allowance	Up to \$150
Non-Elective	Covered	Up to \$210
Standard Contact Lens Fitting Exam Fee*	\$40	Not covered
Specialty Contact Lens Fitting Exam Fee**	\$0 allowance	Not covered


*The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear, or extended wear lenses only.

**The specialty contact lens fitting exam fee applies to a new or existing contact lens user who wears toric, gas-permeable, mono-fit or multi-focal lenses. Member is responsible for any charges over the \$50 allowance.

HEALTH SAVINGS ACCOUNT (HSA)

Contributing to an HSA is a smart way to save for medical expenses— from medical bills and prescriptions to band-aids and OTC medicine. If you do not have an HSA account on file, one will be created for you with HealthEquity.


SOME THINGS TO REMEMBER




Set up your account before you have any medical costs



You can use the money now for medical expenses or let your balance grow for the future.




The money is yours and stays in your account until you use it.




Money can only be used for eligible expenses. Otherwise, there is a tax penalty.

You may be eligible if:


You are enrolled in the **Anthem HDHP Plan**




You are not covered by a spouse's non-HDHP plan or FSA




No one can claim you as an IRS dependent



You are **NOT** enrolled in Medicare, Medicaid, Tricare, or Tricare for Life



You haven't received VA benefits in the last 3 months





**Note: It is your responsibility to familiarize yourself with IRS regulations on HSA eligibility and maintain records of all transactions pertaining to your HSA for audit purposes.*

2026 MAXIMUM CONTRIBUTIONS

	Employee	IRS Maximum
Employee Only	\$4,400	\$4,400
Employee + Dependent (s)	\$8,750	\$8,750
55+ Catch up	\$1,000	\$1,000

 www.healthequity.com

 (866) 346-5800

 Download the Health Equity app

 Download on the App Store

 Available on the Google Play



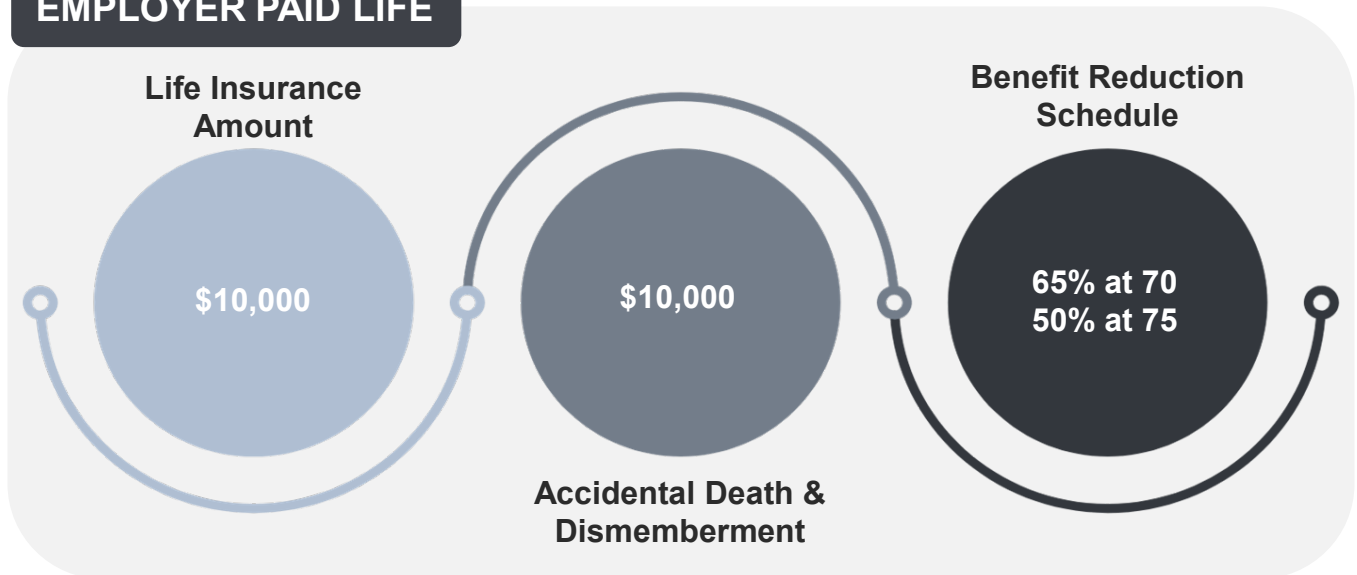
Pay for eligible healthcare expenses
irs.gov/publications
 Publication 969

LIFE INSURANCE



Designating a beneficiary ensures your life insurance goes to the right person, providing them support and avoiding legal issues.

EMPLOYER PAID LIFE



VOLUNTARY LIFE

	Employee	Spouse	Dependent Child(ren)
Benefit Increments	\$10,000 to a maximum of the lesser of 5x your annual salary	\$5,000	\$1,000
Guarantee Issue Amount	\$200,000	30,000	10,000
Benefit Maximum	\$500,000	100,000	10,000
Benefit Reduction Schedule	65% at 70 50% at 75	Reduces at same time as employee	N/A
Timing for rate band changes	At renewal, July 1st		
Additional Details	Employee must elect coverage to cover dependents	Spouse rates and reduction schedule are based on employee age	Coverage limited to age 26

Voluntary Term Life Insurance and Accidental Death & Dismemberment (AD&D)



How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more. AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you buy a minimum of \$10,000 of coverage now, you can increase your coverage in the future up to \$200,000 to meet your growing needs. There would be no medical underwriting to qualify for coverage.

What else is included?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to \$500,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. **These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.** Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you may apply for coverage for:

You:	Choose from \$10,000 to \$500,000 in \$10,000 increments, up to 5 times your earnings. You can get up to \$200,000. This is the amount of coverage you can qualify for with no medical underwriting.
Your spouse:	Get up to \$100,000 of coverage in \$5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to \$30,000 with no medical underwriting, if eligible (see delayed effective date).
Your children:	Get up to \$10,000 of coverage in \$1,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children live birth to 6 months is \$1,000.

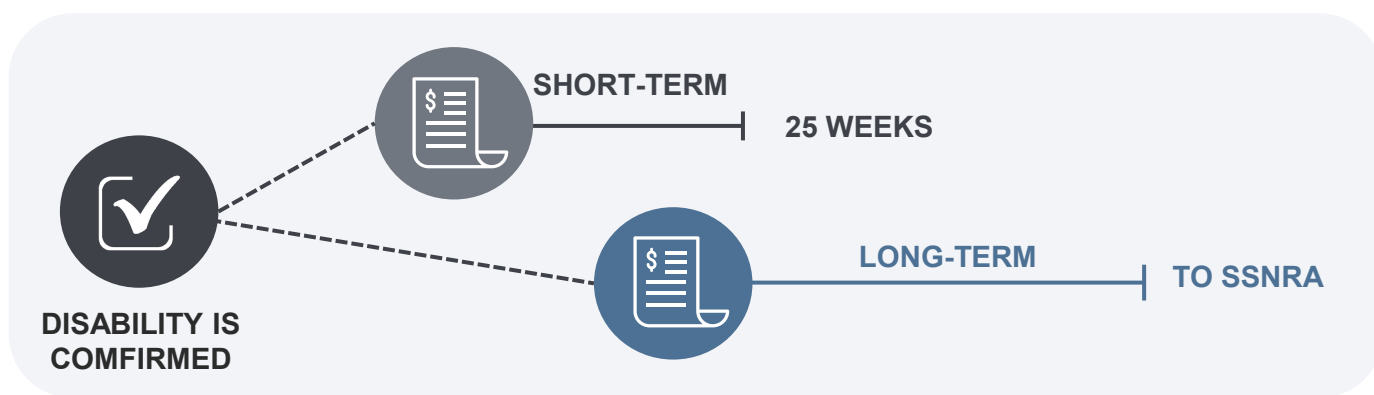
Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	Get up to \$500,000 of AD&D coverage for yourself in \$10,000 increments to a maximum of 5 times your earnings.
Your spouse:	Get up to \$100,000 of AD&D coverage for your spouse in \$5,000 increments, if eligible (see delayed effective date).
Your children:	Get up to \$10,000 of coverage for your children in \$1,000 increments if eligible (see delayed effective date).

No medical underwriting is required for AD&D coverage.

DISABILITY INSURANCE

VOLUNTARY SHORT-TERM EMPLOYEE PAID	LONG-TERM - EMPLOYER PAID
BENEFIT AMOUNT	
60% of Earnings	60% of Earnings
BENEFIT MAXIMUM	
\$1,300 per week	\$5,000 per month
DEFINITION OF DISABILITY	
Based on your own occupation	2 year own occupation, any occupation thereafter
BENEFITS BEGIN AFTER	
7 days for Accidents 7 days for Illness	180 days
MAXIMUM BENEFIT PERIOD	
25 weeks	Social Security Normal Retirement Age
PRE-EXISTING CONDITION LIMITATIONS	
3/12 Any condition treated in 3 months before coverage starts causes a disability within 12 months of coverage	3/12 Any condition treated in 3 months before coverage starts causes a disability within 12 months of coverage



HOW TO LEARN MORE



www.unum.com/employee



(866) 679-3054



Short Term Disability Insurance

How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance replaces part of your income while you recover. As long as you remain disabled, you can receive payments for up to 25 weeks.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Short Term Disability Insurance pays you a weekly benefit if you have a covered disability that keeps you from working.

What else is included?

Cesarean section benefit

If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks unless you return to work before the end of the time.



Consider your expenses

Utilities	\$
Housing	\$
Groceries	\$
Transportation	\$
Child care/Elder care	\$
Medical/Personal care	\$
Education	\$
Insurance	\$

How much coverage can I get?

You*	<p>You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week.</p> <p>Cover 60% of your weekly income, up to a maximum benefit of \$1,300 per week. The weekly benefit may be reduced or offset by other sources of income.</p> <p>*See the Legal Disclosures for more information.</p>
-------------	--

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Elimination period (EP)

This is the number of days that must pass between your first day of a covered disability and the day you can begin to receive your disability benefits.

Your benefits would begin after you become disabled for 7 days.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 25 week benefit duration.

Disability benefits worksheet

Calculate your weekly disability benefit

\$ _____	÷ 52 =	\$ _____	x	60%	=	\$ _____
Enter your annual earnings		Your weekly earnings		(Max % of income covered)		Maximum weekly benefit available (If the amount exceeds the plan max of \$1,300, enter \$1,300.)

* The maximum covered annual income is \$112,666.

Benefit amount may vary. Only if only if the maximum covered annual income is \$112,666.

Long Term Disability Insurance



How does it work?

This employer-paid coverage provides a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer. You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

Your employer is paying the cost of this coverage. You can use the benefits however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

How much coverage can I get?

You*	<p>You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week.</p> <p>Cover 60% of your monthly income, up to a maximum payment of \$5,000.</p> <p>*See the Legal Disclosures for more information.</p>
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The monthly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxes on certain benefit payments. See your tax advisor for details.

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security (SS) normal retirement age. If you become disabled after your normal retirement age, check with your employer for the maximum length of time applicable to you.

Long Term Disability Insurance can replace part of your income if a disability keeps you out of work for a long period of time

What else is included?

Work-life balance employee assistance program

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

ACCIDENT INSURANCE



Accident insurance provides you with a cash payment if you get injured in an accident. This money can help cover medical bills, lost wages, or other expenses while you recover.

ACCIDENT INSURANCE COVERS INCIDENTS SUCH AS:



INJURIES

- Fractures
- Dislocations
- Concussions
- Lacerations
- Burns
- Eye injuries
- Ruptured discs

MEDICAL TREATMENT

- Ambulance
- Emergency care
- X-rays
- Hospital admission

HOSPITALIZATION

- Hospital admission
- Confinement

Accident insurance covers both short-and long-term injuries. Payments are made to you and not the healthcare provider, allowing you to use the funds however you see fit.



Group Accident Insurance



How does it work?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 10% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.

CRITICAL ILLNESS



Critical illness insurance provides you with a lump sum payment if you're diagnosed with a serious illness like cancer, heart attack, or stroke. This money can help cover medical bills, lost income, or other expenses while you recover.



SOME OF THE COVERED ILLNESSES INCLUDE:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant
- End Stage Renal Disease
- Coronary Bypass Surgery

Benefit payments are determined by the medical diagnosis and coverage level. Payments are made to you and not the healthcare provider, allowing you to use the funds however you see fit.



Group Critical Illness Insurance



How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive \$50 for getting a covered Be Well Benefit screening test, such as:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Annual exams by a physician include sports physicals, well-child visits, dental and vision exams • Screenings for cancer, including pap smear, colonoscopy • Cardiovascular function screenings | <ul style="list-style-type: none"> • Screenings for cholesterol and diabetes • Imaging studies, including chest X-ray, mammography • Immunizations including HPV, MMR, tetanus, influenza |
|---|--|

Who can get coverage?

You:	Choose from \$5,000 to \$20,000 of coverage in increments of \$5,000 with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses

- | | |
|--|---|
| <ul style="list-style-type: none"> • Heart attack • Stroke • Major organ failure • End-stage kidney failure • Sudden cardiac arrest | <ul style="list-style-type: none"> • Coronary artery disease
Major (50%):
Coronary artery bypass graft or valve replacement • Minor (10%):
Balloon angioplasty or stent placement |
|--|---|

Cancer conditions

- | | |
|---|---|
| <ul style="list-style-type: none"> • Invasive cancer — all breast cancer is considered invasive • Non-invasive cancer (25%) | <ul style="list-style-type: none"> • Skin cancer — \$500 |
|---|---|

Progressive diseases

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D
- Occupational PTSD
- Paid at 25%:**
- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

HOSPITAL INDEMNITY



Hospital indemnity insurance is a type of supplemental insurance that gives you a cash payment if you're hospitalized. This money can help cover costs that your regular health insurance doesn't pay for.



HOW YOU CAN USE IT:

- **Deductibles**
- **Copays**
- **Everyday expenses while recovering**

Hospital indemnity insurance payments are made to you and not the healthcare provider, allowing you to use the funds however you see fit.





Group Hospital Insurance



How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Group Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.



Since our founding in 1848, Unum has been a leader in the employee benefits business.

Innovation, integrity and an unwavering commitment to our customers has helped us become a global leader in financial protection benefits.

Coverage may vary by state. See exclusions and limitations.

This plan has a pre-existing condition limitation. See the disclosures for more information.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at <https://www.medicare.gov/publications/02110-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.pdf>.

WELLNESS

PROGRAM HIGHLIGHTS

- Members can Monitor Physical Activity & Participate in a Weight Management Programs!
- Members can also view achievements right on the home page of their account.
- And Complete Wellness Challenges and more!

HOW TO EARN

- Register on the app or WellWorks For You website where you can sign up for activities and begin working towards a healthier tomorrow!



ELIGIBILITY

- **You must be actively employed at the time of the payout to receive the HSA contribution**
- All full-time, benefit eligible employees
- All spouses enrolled in the medical plan

Reminder!

The WellWorks program plan year, ends November 30th, 2026

HOW TO LEARN MORE



www.wellworksforyou.com



(800) 425-4657



Download the Wellworks For You app





Get Started

Welcome to your 2026 Wellness Program. All medically-eligible employees and spouses / partners covered by the medical plan can earn an incentive by completing Steps 1-3 by November 30, 2026.

Earn Your Incentive

You must complete the steps below to be eligible for any HSA contribution.

- Step 1: Physician Results Form
- Step 2: Know Your Number Assessment
- Step 3: One (1) Age/Gender Preventive Screening

Please Note: You must be actively employed at the time of the payout to receive the HSA contribution.

Tier	Eligible	Requirements	Incentive
Tier 1	Employees and Spouses/Partners	Steps 1-3	\$650 HSA Contribution for employees; \$550 HSA contribution for Spouses/Partners
Tier 2	Employees	Tier 1 and Complete Additional Activities	Additional \$50 HSA contribution for every 50 points earned, up to \$150

Log in to the Wellness Portal

To track your participation, you must be registered under the Heidelberg University Portal. Follow the steps below to log in.

Your account has been created for you.

1. Go to www.wellworksforyoulogin.com
2. Select **Login**
3. Accept the terms of the **Consent Form**
4. Fill in the required information

Click "Forgot Username" or "Forgot Password" to recover your login; if needed, utilize the Live Chat feature for assistance.

	Employee & Spouse
Username Format	Heidelberg_First Name + Last Name
Password Format	Birthdate in MMDDYYYY
Example	UN: Heidelberg_MarySmith PW: 02241980

Please Note:

Use the temporary password for your first login only—you'll be prompted to set a new one. If you've logged in before, use your existing password.

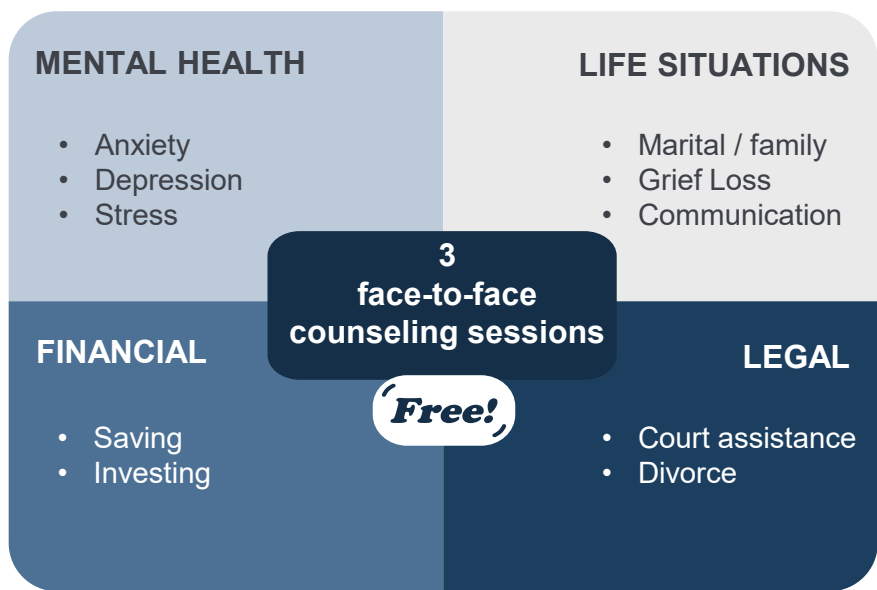
In accordance with HIPAA confidentiality laws, your individual data is accessible only to you and the third-party vendor, Wellworks For You.

EMPLOYEE ASSISTANCE PROGRAM



SERVICES PROVIDED

Unum provides in-person and 24/7 online services for individuals, married couples, and families for a variety of situations. Common situations included, but are not limited to:



FREE SERVICES

Each eligible family member may receive up to 3 face-to-face counseling sessions and 24/7 telephonic counseling, work/life balance resources.

CONFIDENTIALITY

Unum services are fully confidential, and no information, including your name, will be shared without your written consent.

The only exceptions are if the counselor must warn about a serious threat or report child or elder abuse as required by law.

CONTACT



www.unum.com/lifebalance



(800) 854-1449





Help, when you need it most

With your **Employee Assistance Program** and **work-life balance services**, confidential assistance is as close as your phone or computer.



Employee Assistance Program (EAP)

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.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Job stress, work conflicts
- Relationship issues, divorce
- Family, parenting problems
- Anger, grief, loss
- And more



Work-life balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our work-life Specialists can answer your questions and help you find resources in your community.

Ask our work-life Specialists about:

- Child care
- Identity theft
- Elder care
- Legal questions**
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills
- And more

Who is covered?

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.



Better benefits at work.™

*The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

**State mandated limitations apply for work-life balance employee assistance program services in WA.

Work-life balance employee assistance programs may not be available in New York. Other state-specific restrictions may apply based on the product offering.

The Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

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EN-2058-4 FOREMPLOYEES (5-25)

unum.com

IMPORTANT PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator.

Plan Administrator:

Heidelberg University
Victoria Black
vblack@heidelberg.edu

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Notice Regarding Special Enrollment Rights

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.

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).

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. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

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.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

Notice Regarding Michelle's Law

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

Notice Regarding Patient Protection Rights

Your Group Health Plan (identified at the beginning of this section) generally allows the designation of a primary care provider.

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Group Health Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the Plan Administrator (identified at the beginning of this section) or issuer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

Health Insurance Marketplace Coverage Options and Your Health Coverage

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.5% (indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.5% (indexed annually) of the employee's household income. (An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Plan Administrator (identified at the beginning of this section)..

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional 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” means providers and facilities that haven’t signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan’s deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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 they can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 balance 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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have these protections:

- You’re only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “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 in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at <https://www.cms.gov/nosurprises/consumers>. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

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 January 31, 2026. Contact your State for more information on eligibility –

<p style="text-align: center;">ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p style="text-align: center;">ALASKA – Medicaid</p> <p>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</p>
<p style="text-align: center;">ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p style="text-align: center;">CALIFORNIA – Medicaid</p> <p>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</p>
<p style="text-align: center;">COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>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</p>	<p style="text-align: center;">FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268</p>

<p align="center">GEORGIA – Medicaid</p> <p>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</p>	<p align="center">INDIANA – Medicaid</p> <p>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</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>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</p>	<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p align="center">KENTUCKY – Medicaid</p> <p>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</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p>
<p align="center">MAINE – Medicaid</p> <p>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</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>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</p>

	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 and CHIP
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 Rlte 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 January 31, 2026, 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

Turning Age 65 and Becoming Medicare Eligible

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage and Part D (prescription drug) coverage at your cost. If you do enroll in Medicare, this plan and Medicare will coordinate benefits with one plan paying as primary and the other paying as secondary, as determined by Federal law. When Medicare is primary, some carriers require the participant enroll in Medicare Part B; members should call their medical carrier member services line to identify when this is required.

For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner, or any dependent resides at a different address than you, please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) 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. The prescription drug coverage offered by the Group Health Plan 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 15 through December 7. 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 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 your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 U.S. Social Security on the web at www.socialsecurity.gov or call 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).

Wellness Program Privacy Notice

Wellworks is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete biometric screening, blood test, health risk assessment, medical exam, and more. You are not required to complete any wellness program components; however only those who choose to participate will qualify for incentives as described as detailed in the wellness section of your benefit guide or through wellness program promotional materials that describe available rewards.

Additional incentives may be available for employees who choose to participate in health-related activities or achieve certain outcomes as detailed in the wellness section of this guide or through wellness program promotional materials. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard.

The information collected by the wellness program from your biometric screenings, blood test, HRA, or medical exam will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information.

Although the wellness program and Heidelberg University may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for the purpose of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Notwithstanding these precautions, it's important to keep in mind that there is always a possibility that your information could be used or shared in ways not originally intended. If you are concerned about sharing your medical information through the wellness program, you may choose to complete your screening directly with your physician, or opt out of the screening entirely. It's helpful to weigh the health benefits of regular screenings alongside any privacy concerns you may have.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Plan Administrator.

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available, free of charge, by contacting your Plan Administrator (identified at the beginning of this section)

