Health Benefits Open Enrollment Guide

For Plan Year 2020

January 1, 2020 through December 31, 2020

Dear Heidelberg Faculty & Staff:

Welcome to Heidelberg University's annual benefits Open Enrollment period for plan year 2020. This packet is designed to provide information regarding your benefits and help you make informed benefit decisions during your Open Enrollment period. Open Enrollment for new employees begins with the 1st day of employment and runs for 31 days. The Annual Open Enrollment period for the 2020 plan year begins **Monday**, **October 21st and ends Monday, November 25th, 2019**. All benefits-eligible employees are required to enroll or waive coverage by completing and submitting the required paperwork for each of the benefits offered by Heidelberg University no later than the final day of their respective open enrollment period.

Understanding Heidelberg Health Benefits

Heidelberg's self-insured health benefits costs are made up of three main components: ***participant medical and prescription drug claims***, subject to individual stop-loss limits; ***fixed administrative expenses***, which include third-party stop-loss insurance coverage; and the ***employee's health care premiums***, which offset a portion of these costs. Historically, our self-insured medical claims can vary greatly from year to year, often driven by a few very large claims. While the Affordable Care Act remains intact, and under the Equal Employment Opportunity Commission, Heidelberg's plan is required to make sure the health benefits program, including the wellness components and discounts, are available, affordable, and compliant.

The High Deductible Health Plan (HDHP) continues to be the sole plan option available for Heidelberg employees and their dependents. The deductible level for single has increased to $2,800 per IRS rules. Monthly premium rates for the medical/prescription, vision, and dental plans for 2020 are listed on page 11 of this document. Premiums for supplemental programs are set by the carrier. All rates will be confirmed via a confirmation sheet following your election of benefits.

Offering health and wellness benefits is important to Heidelberg. Our short-term plan continues to be cost containment so this employment practice can continue as we grow and accelerate forward. The long-term plan is to successfully engage plan participants as shareholders in a long-term benefits strategy. Under the four key objectives – **Cost Containment, Prevention & Wellness, Personal Advocacy & Responsibility,** and **Communication** – shared by the institution as well as the participants, wellness initiatives will help shape wellness programming and education efforts. The Health Benefits Cost Containment Committee is completing a healthcare consulting search and are close to being able to announce a new partner for 2020. We will look for that new partner to participate in a review of our plan components, the development of strategic opportunities, and a stronger benefits menu for our employees.

Under our key objectives with continued review, participation, and discussion, and with our new consulting partner to be named soon, 'Berg Health Benefits should continue to grow into a progressive and competitive program. We encourage you to spend time reviewing the information provided in this guide as well as to speak with members of the Office of Human Resources and the various benefits representatives who will be available during open enrollment.

In good health,

Margaret C. Rudolph
Chief Human Resources Officer
Title IX Coordinator

Ronda Winkler
Payroll & Benefits Manager

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Questions? Human Resources is happy to assist you!
rwinkler@heidelberg.edu or ext. 2181 OR mrudolph@heidelberg.edu or ext. 2111

Coverage Effective Date

Health care coverage for a newly hired employee (and eligible enrolled dependents) may begin as early as your hire date and up to thirty-one (31) days after your date of hire. **You must select an effective date or coverage will default to the date of hire and all premiums due will be calculated based upon that date.** That means the first payroll deduction may include a pro-rated amount and/or may be more than the typical monthly or bi-weekly amount.

If you do not return your health plan enrollment form within 31 days of hire, you will be considered to have "opted out" of coverage (waived) and will not be eligible to enroll in the benefits plan until the next open enrollment period or until you have a qualifying event (e.g., loss of other coverage). Enrollments based on a qualifying event are effective the date of that qualifying event (i.e., birth of child).

Who Is Eligible

Employees

A benefits eligible Heidelberg employee is defined by the Summary Plan Document as one of the following:

A. An individual employed as a staff employee by the Employer on a regular, full-time basis for at least one thousand forty (1040) hours per year; or,
B. An individual employed as a full-time faculty employee by the Employer for at least the required half (1/2) time, as determined by the Provost's Office.

In addition, benefits eligible employees are also eligible to participate in the Flexible Spending Accounts as well as the supplemental benefits programs outlined in this guide. Enrollment for coverage occurs:

A. When a faculty or staff member initially becomes benefits eligible;
B. Each year during the open enrollment period (for the beginning of the next Plan Year – Jan 1);
C. Within 31 days of a qualifying event / change (examples: birth of a child, marriage, divorce, loss of other coverage).

Dependents

The following dependents are eligible for health care benefits through Heidelberg University, as defined by the Summary Plan Document:

- The Participant's legal spouse. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married; or,
- The Participant's domestic partner; or
- A "child" 26 years of age or younger who:
  - Is the Participant's natural child, adopted child, stepchild, foster child, a child for whom the Participant has legal guardianship, a child of a domestic partner or is a child placed for adoption with the Participant; or,
  - Is a child who is related to the Participant who is considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986 as amended.

  A child may continue to be covered under the health care plan until age 26. Coverage continues through the end of the month in which they turn 26 or otherwise no longer meets the requirements listed above. Under certain circumstances, coverage may continue after age 26 for a dependent child who cannot support themselves because of a developmental or physical disability. Contact Human Resources for more information. Sufficient proof of dependent status may be required at the Plan Administrator's discretion.

The complete Summary Plan Document contains this and other important information!

Making Plan Changes During the Plan Year

Your elections will remain in effect through the end of the plan year (December 31st). Your next opportunity to change your elections or your participation will be during the next Open Enrollment period, held each year, unless you have a qualifying event and/or change in status, for example:

- You marry or divorce;
- You add a dependent child to your family through birth or adoption;
- An enrolled family member dies;
- You (or your spouse/partner) go on an unpaid leave of absence;
- You (or your spouse/partner) have a significant change in employment status (for example, you go from part-time to full-time or vice versa, or your spouse loses or gains employment);
- You waive medical coverage for yourself or your family members because of other health care coverage — and you lose that other coverage for certain reasons.

Election changes must be made within 31 days of the qualifying status change or you must wait until the next Open Enrollment. Have a change in enrollment? Complete a Change Form.

Did you know the Saurwein Health & Wellness Center is open to Heidelberg employees and their spouse/partner? Contact the Director at x2594 to register & take a tour!

Your Heidelberg Health Benefits Plan Options

The ***'Berg Health Benefits Plan*** offers one option for health care coverage. If you have other medical coverage and don't need coverage through the University, you can opt out and avoid payroll deductions for health care.

'Berg Benefits Plan High Deductible Health Plan (HDHP)	**Waive/Opt Out**
Payroll Deduction	No Payroll Deduction
High Deductible	No Coverage / No Plan Benefits (medical & prescription coverage)
Includes medical & prescription coverage	

The HDHP plan includes a comprehensive medical and prescription benefit including preventive care, office visits, hospitalization, etc. There is a higher level of benefit when services are sought IN-NETWORK versus OUT-OF-NETWORK. Plan summary documents are available HERE as well as from the Office of Human Resources.

Coverage through the Marketplace:
Heidelberg's health benefits program (medical and Rx coverage) meets the minimum coverage and affordability tests. If you waive Heidelberg's coverage, and do not have access to other care, you may wish to explore the public marketplace (www.healthcare.gov) for coverage. Additional information can be found in the Marketplace Coverage Notice located in this guidebook.

KEY POINTS TO UNDERSTAND:

- There are specific IRS rules for participating in pre-tax health savings accounts (such as health savings account and/ or a flexible spending accounts). You are highly encouraged to speak with a tax advisor for the best advice for your own unique situation.
- **During this Annual Open Enrollment, if you are currently covered under Heidelberg's health plan, and you do NOT return your benefits forms for 2020, your coverages from 2019 will remain in effect. If you are not currently covered under Heidelberg's health plan, and you do NOT return your benefits forms for 2020, you will remain without coverage.**

Medical Highlights & Providers

Your preferred provider network will continue to be ***Medical Mutual of Ohio*** *and* ***Mutual Health Services*** will continue to be our medical benefits claims administrator. Using network providers lowers your out-of-pocket costs because the percent you pay is based on lower negotiated fees, or allowable charges. Out-of-network providers may bill you for the amount over the allowable charge, a practice called "balance billing."

The following chart lists the main features and most commonly used benefits. For a more detailed chart, please review the Plan Summary.

Newly hired employees must turn in their enrollment form within 31 days of their hire date or they will have waived coverage.

'Berg Benefits Plan - HDHP	
Deductible (In-network)	$ 2,800 per person / $ 5,000 per family
Annual Out-of-Pocket Maximum (includes deductible)	$ 2,800 per person / $ 5,000 per family
Co-Insurance (In-network)	100% after deductible
Office Visit Co-Pays (Primary Care / In-network)	No Office Visit Co-Pay
Diagnostic Testing (In-network)	100% after deductible
Lifetime Maximum	$ Unlimited
Hospital Admissions	100% after deductible
Preventive Care	***100%***

Finding a Network Provider

You save money when you use network providers. Medical Mutual of Ohio providers agree to accept the allowable charge as full payment for medically necessary covered services. And, network providers will bill Mutual Health Services directly when they furnish covered services to you.

Find out if your healthcare provider belongs to the network.

Or you can call Mutual Health Services at (800) 367-3762 for assistance.

Pharmacy Highlights

Heidelberg's Health Benefits includes a pharmacy benefit plan.
Your Mutual Health Services ID card is also be used for your pharmacy benefits. ID cards, if you are a new enrollment or making a change, will be mailed directly to your mailing address on file.
You may always request additional cards from HR or by creating an account with Mutual Health Services and requesting new cards. You can obtain specific prescription information by visiting CVS Caremark.

You are encouraged to use generic drugs whenever possible. For more information on generics and alternatives for non-preferred brand drugs, please visit www.caremark.com.

NOTE: All prescriptions are subject to the deductible under the HDHP. Once the deductible has been met, the co-pays begin until the out-of-pocket maximum is met.

	HDHP
***Network Pharmacy* - 30 day supply**	
Generic	$ 5.00 copay after deductible
Brand	$ 20.00 copay after deductible
Non-Preferred Brand	$ 40.00 copay after deductible
***Mail Order Pharmacy* - 90 day supply**	
Generic	$ 10.00 copay after deductible
Brand	$ 40.00 copay after deductible
Non-Preferred Brand	$ 80.00 copay after deductible

Benefit ID Cards…Which is Which?

Your health benefits card includes your medical AND prescription coverage details and should be provided to your health care provider and / or pharmacist at each visit.

If you participate in the dental and / or vision program, you have a separate card for those benefits.

If you participate in the flexible spending account program, you will receive a Mutual Health Services debit card to use for your qualified medical expense transactions.

Mail Order Prescriptions

If you take certain medications on an ongoing basis, you can save money and time by having those medications filled through CVS Caremark mail order. By having your prescriptions filled through CVS Caremark mail order, you are able to obtain up to a 90-day supply of your medication at the 60-day retail cost, which eliminates multiple trips to your local retail pharmacy and saves you money!

When your doctor prescribes a maintenance drug, ask to have the prescription written for up to a 90-day supply. If your medication must be taken immediately, ask your physician to issue two prescriptions: one for a 30-day supply to be taken to your local pharmacy, and a second for a 90-day supply to be mailed to CVS Caremark.

LOCAL PHARMACY OPTIONS: Remember to utilize a CVS Caremark participating pharmacy for your in-network benefits. Local/nationwide pharmacy chains in the CVS Caremark network include:

The Medicine Shoppe
Kroger
Rite Aid
Discount Drug Mart
Meijer
CVS
WalMart
Target
Walgreens
Most IGA's with Pharmacy Counters

Tax Deferred Savings – Health & Dependent Care Savings Programs

Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you set aside money through pre-tax payroll deductions to pay for certain eligible expenses. The money going into the FSA is not taxed and the reimbursement is not taxed when it's paid to you. So, you pay for eligible expenses with tax-free dollars. There are **two types** of FSAs:

- The **Medical Flexible Spending Account** — permits you to pay for certain out-of-pocket health care costs, such as doctor's office visit copays, deductibles, contact lens solution and more, with pre-tax money.
    - **The maximum amount** you can contribute to your Medical Spending Account is **$2,700** per plan year.
    - Your contribution is deducted in equal installments from each paycheck throughout the year.
    - **If you enroll in the 'Berg Benefits Plan (HDHP), you are eligible for only a Limited Purpose FSA which means you can use flexible spending account dollars for eligible dental and vision expenses only.**
- The **Dependent Care Reimbursement Account** — lets you pay for certain dependent care costs that enable you to work, such as daycare for your child or elder dependent, with tax-free money. This is a reimbursement account – you are reimbursed **after** you pay eligible dependent care expenses.
    - **The maximum contribution** to a Dependent Care FSA, in most cases, is $5,000 for the plan year.

Key points about the Flexible Spending accounts:

- Set aside no more than you think you will use from January 1 (or the date your participation begins) through December 31. Due to IRS rules, you will forfeit any amount left in your FSA after the end of the year. In other words, you have to "use it or lose it."
- Your election is only for the plan year. You must re-enroll each year if you want to keep participating.
- Generally, you can't change or stop your FSA elections during the plan year, so consider your election carefully before you enroll!

Health Savings Accounts

Take charge of your health care spending with a Health Savings Account (HSA). The contributions are tax free, and the money in the account is yours. HSAs allow you to control your own money, year in and year out.

An HSA is your personal health care bank account that you can use to pay qualified medical expenses with pre-tax dollars when you are enrolled in the 'Berg Benefits Plan (HDHP). You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible High Deductible Health Plan (HDHP).
- You are not covered by your spouse / domestic partner's health plan that is not an HSA-qualified High Deductible Health Plan, Health Care Flexible Spending Account or Health Reimbursement Account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- **You are not enrolled in any part of Medicare or TRICARE. This includes Part A!**
- You have not received Veterans Administration health benefits in the last three months.

Your HSA can be used for your qualified expenses and those of your spouse and dependents, even if they are not covered by the HDHP. Many financial institutions offer HSAs as well as debit cards which can be used to pay for qualified expenses. You must have funds available in your HSA to use an associated debit card. There are no receipts to submit for reimbursement, but you must retain all documentation of your qualified expenses for your tax records.

Information on items eligible for reimbursement can be found HERE.

Health Savings Account - How to Enroll

Complete the HSA Banking Information Form and designate the amount you wish to contribute on a pre-tax basis.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open your health savings account with your financial institution AND submit your HSA enrollment form).

The money in this account (including interest and investment earnings) grows tax-free.

As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

A Health Savings Account (HSA) is YOUR account at YOUR financial institution. You own and manage the HSA so take your time and choose a bank you want to work with. Many local and national banks offer HSA programs.

HSA Funding and Limits

The 2020 IRS maximum contributions from all sources for these accounts are:

- **INDIVIDUAL: $ 3,550**
- **FAMILY: $ 7,100**
- **CATCH-UP $ 1,000 (Age 55 and over)**

Payroll deductions for the HSA will be taken in equal increments throughout the plan year – 12 deductions per plan year for those on the monthly payroll and 24 deductions per plan year for those on the bi-weekly payroll.

The HSA for the 'Berg Benefits Plan will be established at a bank of your choice. You are responsible for setting up and managing your own health savings account. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources.

IMPORTANT NOTE:

If you already have an HSA Banking Information Form on file, you do not need to submit a new form, unless you wish to make changes to your current election.

OPEN ENROLLMENT CHECKLIST

2020 Open Enrollment Deadline: Monday, November 25, 2019

New Hires or Qualifying Event: Deadline is 31 days from hire or event.

Open Enrollment Forms: During the annual open enrollment period, for benefits effective January 1, 2020, current benefits-eligible employees are provided with two forms:

- A Benefits Summary Sheet that is pre-populated with your current elections and the premiums that are currently being deducted. (A change requested in the last 7 days may not have been captured.)
- A Mutual Health Services Open Enrollment form (gold paper) that is pre-populated with your current Mutual Health Services enrollment information.

Do you need or want to make a change?

- If yes, mark "YES" on the appropriate line and describe the change needed (i.e., *Cancel coverage*).

Review each form and then sign both forms and return to the Office of Human Resources.

- HR will reach out to you if additional forms are needed and/or there are any questions.

***** Please note: If you are enrolling for the first time, an Enrollment/Change Form is required.**

Review Your Pre-Tax Spending Program Options:

Decide if you would like to participate in a Flexible Spending Account (FSA) for health care and/or dependent daycare expenses. **FSA participation does not continue into the next plan year automatically; you must re-enroll during open enrollment.** If you enroll in the 'Berg Benefits Plan with a health savings account, you are eligible for the Limited Purpose FSA only. The Limited Purpose FSA provides flexible spending dollars for dental and/or vision expenses ONLY.

- If you wish to enroll, **complete a Mutual Health Services FULL FSA, DEPENDENT CARE REIMBURSEMENT ACCOUNT, or LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT form.** The IRS requires a new enrollment form each year for flexible spending. Your 2019 election will NOT continue into 2020 unless you complete a new form. Forms may be requested from the Office of Human Resources.
- ***Health Savings Account:*** If you are eligible to contribute to a Health Savings Account enroll at the bank of your choice. **Return the HSA Banking Information Form if you wish to have contributions withheld via payroll deduction**. If you already have an HSA payroll deduction you do not need to complete this form unless you wish to change your deduction amount and/or financial institution/bank.

Review Your Supplemental Benefit Options:

- ***Dental / Vision:*** Review your dental and vision options and select the plan(s) that best meet your needs and budget OR waive coverage. Please note that some rates have changed or may change based upon the carrier. **Complete a Guardian Benefit Election Form (vision) or Humana Change form (dental)** for the plan option(s) you are changing OR that you are waiving for 2020. A waiver of coverage will remain in effect until you elect coverage because of a qualifying event or during a future open enrollment period.
- ***Life Insurance:*** All benefits eligible employees are provided a $10,000 term life insurance/AD&D insurance policy. This benefit is paid for by the University. **If needed, complete a Mutual of Omaha Beneficiary Designation form**.
- ***Voluntary Supplemental Benefits:*** Consider whether you want to make any additional elections under the voluntary supplemental programs: life and accidental death and dismemberment (AD&D) insurance program, short term disability insurance, critical illness benefits, accident insurance, or universal life insurance. **If needed, request and complete a voluntary benefits enrollment kit** if you would like to participate. Premiums will not be collected until coverage is approved by the appropriate underwriter.

Return all enrollment forms to Human Resources within the annual open enrollment window (by Monday, November 25, 2019) OR within 31 days of your hire date for new hires.

2020 Health Benefits Plan (medical & Rx) MONTHLY Rates

PLAN TYPE	ANNUAL SALARY TIER	MONTHLY RATE
Employee Only	≤ $28,500	$ 101
	$28,501 - $47,499	$ 150
	$47,500 - $75,000	$ 188
	≥ $75,001	$ 226
Employee + Spouse or Partner	≤ $28,500	$ 302
	$28,501 - $47,499	$ 325
	$47,500 - $75,000	$ 411
	≥ $75,001	$ 494
Employee + Child(ren)	≤ $28,500	$ 277
	$28,501 - $47,499	$ 292
	$47,500 - $75,000	$ 377
	≥ $75,001	$ 453
Family	≤ $28,500	$ 383
	$28,501 - $47,499	$ 412
	$47,500 - $75,000	$ 510
	≥ $75,001	$ 619

2020 Vision MONTHLY Rates

	Employee Only	Employee + Spouse / Partner	Employee + Child(ren)	Family
VSP	$ 14.94	$ 25.13	$ 25.63	$ 40.58
DAVIS	$ 11.40	$ 18.92	$ 19.32	$ 30.35

2020 Dental MONTHLY Rates

Humana	Employee Only	Employee + Spouse / Partner	Employee + Child(ren)	Family
Low Plan	$27.03	$54.05	$68.92	$95.94
High Plan	$32.25	$64.48	$82.21	$114.46

Voluntary Supplemental Benefits

Everyone has different benefit needs and the 'Berg Health Benefits program offers a variety of supplemental, voluntary benefit plans to help meet your needs. You are eligible to enroll in these benefit programs at any time, however, if enrolling outside of the open enrollment period, you may be required to complete additional information including an evidence of insurability form and your enrollment is subject to underwriting approval. These programs are voluntary and, in most cases, utilize a post-tax payroll deduction. In addition, these benefits are typically portable, meaning you can take the benefit with you in the event you leave Heidelberg employment. Guardian provides the vision benefit as well as short-term disability, critical illness, and accident insurance described below:

- **Short Term Disability Benefits** — Your paycheck is one of your greatest assets. Disability insurance helps replace lost income if you have an accident or illness that prevents you from working. Unfortunately, disabilities occur more often than you think. A short term disability policy can offer a weekly benefit amount as soon as eight (8) days after your illness or injury. Premium rates are based upon the amount of weekly benefit you select and your age.
- **Critical Illness Benefits** — Critical illness insurance covers what medical and disability insurance doesn't pay for – uncovered medical and / or non-medical, daily expenses associated with critical illnesses. CI benefits pay you to assist in offsetting medical and non-medical expenses (such as deductibles and travel expenses). Premium rates are based upon the amount of benefit you select (minimum $5,000), who you are covering (employee, spouse, child), and your age at election.
- **Accident Benefits** – Some things in life are out of your control – having an accident is one of them. Accident insurance ensures you are covered for specific services related to an accidental injury or loss and provides you with additional financial resources. Premium rates are based upon who you cover.

A complete enrollment kit for the above listed supplemental benefits is available from the link below or in hard copy from the Office of Human Resources. Additional questionnaires and / or an evidence of insurability may be required for underwriting purposes.

- Enrollment Kit – Monthly Payroll
- Enrollment Kit – Bi-Weekly Payroll

Supplemental Benefits…

In addition to the vision and dental programs, these voluntary supplemental benefit programs may help you balance your individual / family needs without breaking the bank.

Life and Accidental Death & Dismemberment Insurance

The University provides basic Life and Accidental Death and Dismemberment Insurance— plus the option to buy Supplemental Life and Accidental Death and Dismemberment (AD&D) insurance. This benefit is provided through Mutual of Omaha Life Insurance

- **Life insurance** — The University provides, at no cost to you, a $10,000 Basic Life Plan. In addition, you may buy up to the greater of 5X your salary or $500,000 of supplemental coverage in $10,000 increments.

  You may elect voluntary supplemental coverage for yourself up to a maximum of $100,000 with no medical underwriting if you apply within 31 days of your hire date. Eligibility for amounts over $100,000 is subject to medical evidence of insurability. You may also select coverage for your spouse / partner equal to an amount you select for yourself up to $35,000 with no medical underwriting in $5,000 increments. You may select coverage for your dependent children to an amount up to $10,000 in increments of $5,000.

  AD&D insurance — The University provides, at no cost to you, a $10,000 AD&D policy. You may buy additional coverage for yourself and dependents. This optional coverage provides a lump sum benefit to you or your beneficiary if you or a covered family member dies or suffers certain injuries as the result of an accident. As a new employee, you may enroll within 31 days of your hire date. If you do not enroll when you are first eligible, you may enroll during any Open Enrollment period or if you have a major life event, but may be required to complete an evidence of insurability form by Mutual of Omaha.

- **Beneficiary Information** – In the event of your death, Mutual of Omaha will rely on your completed beneficiary form to issue the benefit. Without a completed beneficiary form, Ohio law requires that benefits are distributed in a strict order and may require action in Probate Court. If you have had a "life" event in 2018 (i.e., marriage, divorce), did you also update your beneficiary form? Not sure? You can completed a new beneficiary form at any time and submit it to the Office of Human Resources to remain on file with your benefits paperwork.

Required Notices

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and,
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the *Notice of Privacy Practices*, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources.

HIPAA Pre-existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is under the age of 19.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, Children's Health Insurance Program (CHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates of creditable coverage. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a lapse in coverage) a plan may not have to count the coverage you had before the lapse. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day lapse.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Human Resources.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse or partner) because of other health insurance or group health plan coverage, you may be able to later 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 towards your or your dependents' other coverage).
Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Elimination of the coverage option a person was enrolled in and another option is not offered in its place;

- Reaching the plan's lifetime benefit maximum on all benefits, if the person is covered under a separate plan or a single plan with multiple options and the other option has a higher lifetime maximum, or the benefits paid under the first option were not integrated with the second option;
- Failing to return from an FMLA leave of absence; and,
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 31 days after the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact Human Resources.

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).

Important Notice from Heidelberg University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Heidelberg 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:

- 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.

Heidelberg University has determined that the prescription drug coverage offered 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through 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 Heidelberg University coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current Heidelberg University coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Heidelberg 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: 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 Heidelberg University 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 or 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 Medicare Part D 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).

Heidelberg University Contact: Margaret Rudolph, Chief Human Resources Office / Title IX Coordinator

Heidelberg University 'Berg Benefits Program ERISA Wrap Document can be found on Server Six. The ERISA Wrap Document includes a listing of all benefit providers as well as additional required notices.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% 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.[1]

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 Margaret Rudolph, Chief Human Resources Officer.

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Heidelberg University	4. Employer Identification Number (EIN) 34-4428219	
5. Employer address 310 E Market Street	6. Employer phone number 419-448-2000	
7. City Tiffin	8. State OH	9. ZIP code 44883
10. Who can we contact about employee health coverage at this job? Margaret Rudolph, Chief Human Resources Office & Title IX Coordinator or Ronda Winkler, Payroll & Benefits Manager		
11. Phone number (if different from above) 419-448-2111 or 419-448-2181	12. Email address hr@heidelberg.edu	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are: Regular full-time and designated significant part-time employees who are regularly scheduled and work twenty (20) hours or more each week of the year.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are: Legal Spouse; or Domestic Partner; or A child (natural child, adopted child, stepchild, Foster Child, a child for whom the participant has Legal Guardianship, a child of a Domestic Partner or is a child Placed For Adoption with the Participant and is less than 26 years of age.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

DEFINITIONS

(Complete listing of Term and Definitions is found in the Summary Plan Document and Amendments.)

ACTIVELY AT WORK OR ACTIVE WORK
The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the Company. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; a member of the Board of Directors; temporary, free-lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively At Work unless each meets the requirements specified in Section 5.2. This term shall not apply to any provision of this Plan to the extent that such application would be deemed to violate the requirements of HIPAA.

BRAND NAME PRESCRIPTION DRUG
The term "Brand Name Prescription Drug" means a trade name medication.

CALENDAR YEAR
The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. Midnight, through the next December 31st.

COBRA
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE
The term "Coinsurance" means the specific percentage of the Covered Expenses that the Plan will pay, after any applicable Deductible or Copayments are taken. The Covered Person must pay the balance of the Covered Expenses after the Coinsurance has been applied.

COMPANY
The term "Company" means Heidelberg University, the Plan sponsor.

COPAYMENT
The term "Copayment" means a specific dollar amount of the Covered Expenses that the Covered Person must pay before the Plan pays benefits for a particular service or supply. The Copayment does not apply to any Deductible or Out-of-Pocket maximum, and is still payable once the Out-of-Pocket maximum is met.

COVERED EXPENSES
The term "Covered Expenses" means expenses incurred by a Covered Person for any Medically Necessary treatments, services or supplies that are not specifically excluded from coverage elsewhere in this Plan, or other charges that are specifically listed as covered under this Plan.

COVERED PERSON
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

DEDUCTIBLE
The term "Deductible" means the amount of Covered Expenses incurred by a Covered Person in a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.
An Individual Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person.
A Family Deductible limit is the maximum amount that all Family members who are covered under the same Participant must pay in Deductible expense in a Calendar Year. Once this cumulative Family Deductible is reached, the Deductible will be considered satisfied for all Family members covered under the Plan during the remainder of the Calendar Year.

DOMESTIC PARTNERSHIP
The term "Domestic Partner" means an individual in a relationship with the Participant that meets the following requirements:

A. it is a single, dedicated relationship of at least twelve (12) months duration;
B. the parties intend to remain in such relationship indefinitely;
C. the parties share the same permanent residence, and have done so for at least twelve (12) months;
D. the Participant and the other person are not related by blood or a degree of closeness that would prohibit marriage under the laws of the state in which they reside;
E. they are both at least eighteen (18) years of age;
F. they are both mentally competent to consent to contract;

G. neither of them are currently married or in a Domestic Partnership with another person under either statutory or common law; and

H. they are financially interdependent with each other, and able to provide, from time to time, upon the request of the Plan Administrator, at least two (2) of the following documents evidencing such financial interdependence;

1. joint ownership in real property or a common leasehold interest in real property;
2. common ownership of an automobile;
3. a joint bank account;
4. a will that designates either as the primary beneficiary of the other;
5. a beneficiary designation form for a retirement plan or life insurance policy that is signed and completed to the effect that one of them is the beneficiary of the other; or
6. if they reside in a city, state or province that provides for registration of domestic partners, evidence of such registration.

EMPLOYER

The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Internal Revenue Code of 1986, as amended, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the Company. An employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

FAMILY

The term "Family" means a covered Participant and his or her covered Dependents.

FORMULARY

The term “Formulary” means a list of prescription medications complied by the Plan Administrator of safe, effective and therapeutic drugs that are specifically covered under this Plan.

GENERIC EQUIVALENT PRESCRIPTION DRUG

The term “Generic Equivalent Prescription Drug” means a Prescription Drug that has the equivalency of the Brand Name Prescription Drug with the same use and metabolic disintegration. The Plan will consider as a Generic Equivalent Prescription Drug any U.S. Food and Drug Administration (FDA) approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacists and clearly designated by the pharmacist as being generic.

HIPAA

The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

IN-NETWORK

The term “In-Network” means providers who are part of the Plan’s Preferred Provider network at the time such providers render services to Covered Persons that are Covered Expenses under this Plan. The Plan Administrator can provide a listing of providers who are considered to be In-Network for the purposes of this Plan.

OUT-OF-NETWORK

The term “Out-of-Network” means providers who are not part of the Plan’s Preferred Provider network at the time such providers render services to Covered Persons that are Covered Expenses under this Plan.

OUT-OF-POCKET

The term “Out-of-Pocket” means the amount of Covered Expenses that are the responsibility of the Covered Person and that accumulate towards the Plan’s Out-of-Pocket maximum, not including amounts for:

A. Deductibles;
B. Copayments;
C. Out-of-Network routine physical examinations, immunizations, home health care and Hospice expenses;
D. other items specifically excluded from the Out-of-Pocket maximum listed in Section 2.5;
E. expenses that are not covered under this Plan;
F. in excess of the Reasonable and Customary charge for a service or supply;
G. in excess of any maximum benefit listed in the Plan; or
H. attributable to any penalty.

PARTICIPANT
The term "Participant" means a person who meets the eligibility requirements and who is properly enrolled in the Plan.

PHARMACY
The term "Pharmacy" means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

PLAN ADMINISTRATOR
The entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. Heidelberg University is the Plan Administrator as of the Plan Effective Date.

PRESCRIPTION DRUG
The term "Prescription Drug" means any of the following:

A. a U.S. Food and Drug Administration (FDA) approved drug or medicine that, under federal law, is required to bear the legend "Caution: federal law prohibits dispensing without a prescription" or "Rx only;"
B. injectable insulin; and
C. hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Such drug must be Medically Necessary in the treatment of an Illness or Injury, unless specifically listed as a Covered Expense under this Plan.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and that is one (1) of the following:

A. transmitted by electronic media, including:
    1. the internet;
    2. an extranet;
    3. leased lines;
    4. dial-up lines;
    5. private networks; and
    6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium.