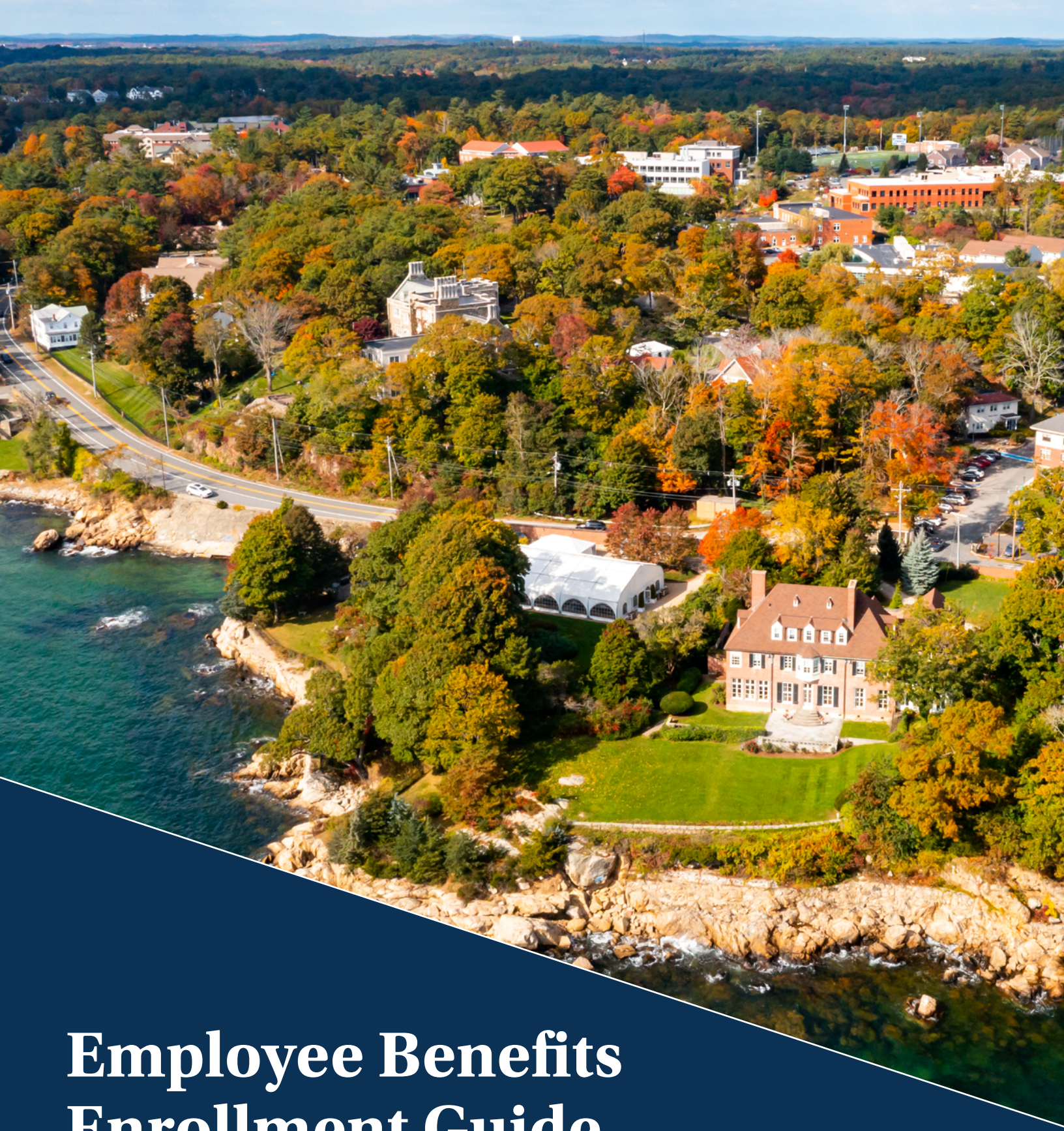


Employee Benefits Enrollment Guide

2023

ENDICOTT COLLEGE

Table of Contents

This information is a simple summary of Endicott College's benefits for employees. For more detailed information, please see the Human Resources (HR) page on the Intranet, which has a Summary of Benefits, or contact HR directly. If anything in this Benefits Guide is in conflict with the Endicott College Faculty Association Agreement, the Agreement prevails. If there is a conflict between any information in this booklet and the Summary of Benefits, the latter prevails.

Endicott College offers a quality benefit package to support our dedicated employees.

These plans are designed to help maintain and improve your well-being, safeguard your loved ones, and provide smart ways to save for the future. We encourage you to explore this benefit enrollment guide and learn how each benefit can make an impact on your life—the more you know, the easier it is to make the best decisions. This is meant to be a summary of benefits offered at Endicott; please see the Human Resources Intranet page for full plan and policy details.

Get to Know Your Benefits

Am I eligible for benefits at Endicott?

The benefits outlined in this brochure are for full-time (35+ hours per week) employees. The exceptions are health insurance, which is available to employees who work 30 hours per week or more, and Paid Medical Leave (PML), which is available to all employees. If you are an Endicott full-time employee, you are eligible to enroll in the benefits described in this guide.

If you are a newly-eligible employee, your medical, dental, and vision benefits will start on the first day of the month following your hire or transfer date. All other benefits are available upon your start date.

Don't forget—you must enroll in benefits within 30 days of your hire/transfer date, or you'll have to wait until the next open enrollment period (unless you have a qualifying event).

Who are my eligible dependents?

In general, eligible dependents are your:

- Spouse, if legally married.
- Child(ren) up to age 26.
- Disabled child(ren) over age 26.

Can I change my benefits when there are changes in my life?

When life changes, make sure you adjust your benefits. You can change your benefits coverage during the plan year if you have a qualifying event. Eligible qualifying events are:

- Your employment status changes, including moving into or out of a role with 30+ hours per week
- Your spouse or eligible dependent loses or gains coverage
- Your legal marital status changes, including marriage, death of spouse, divorce, or legal separation
- Your number of dependents changes, due to the birth of a child, adoption, or death of a dependent
- Your dependent reaches age 26 and is no longer eligible for your plan
- You and/or your dependents move to a new residence outside of the plan's coverage area

You must make your changes in ADP within 30 days of the qualifying event.

Without a qualifying event, benefit selections may only be changed during open enrollment.

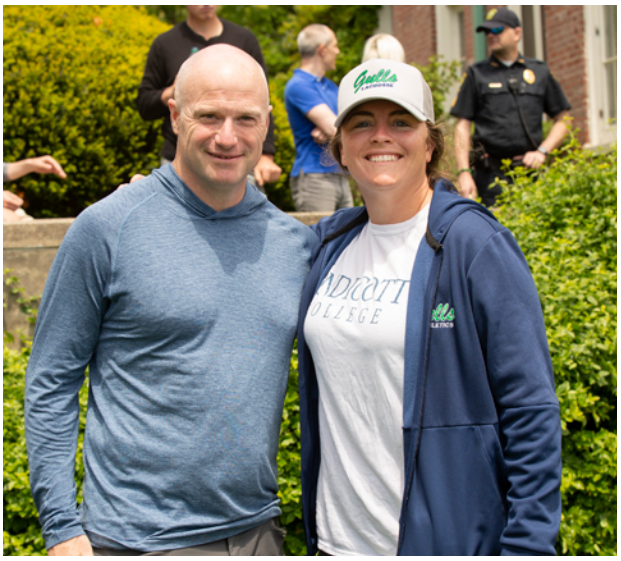
Making changes in ADP after a qualifying event

Immediately following a qualifying event, scan documentation (e.g., marriage certificate, statement of birth, divorce decree, or loss or gain of coverage letter) that confirms your qualifying event and email it to HR.

After receipt of the documentation, HR will create a "life event" in ADP. **Within 30 days of the event**, log in to ADP to make your updated benefit selections.

What happens to my benefits if I go on leave?

If you are being paid by Endicott (through Health Absence, vacation, or personal time) for any part of your leave, your share of your benefits cost will be deducted from that pay. If you are on unpaid leave, you will need to arrange to pay for your share of the benefit premium while on leave in order to maintain your benefits. Endicott will continue to pay its share of your benefit costs for 180 days from your first date of absence. After 180 days, your employment will end and you can enroll in Consolidated Omnibus Budget Reconciliation Act or COBRA. You may be eligible at that time for Long-Term Disability insurance.



2023 Observances, Holidays, & Closures

Reason	Date	Type
New Year's Day	January 2 (observed)	Holiday
Martin Luther King, Jr. Day	January 16	Holiday
Presidents' Day	February 20	Holiday
Patriots' Day	April 17	Holiday
Memorial Day	May 29	Holiday
Juneteenth	June 19	Holiday
Independence Day	July 4	Holiday
Labor Day	September 4	Holiday
Columbus Day	October 9	Holiday
Day before Thanksgiving	November 22	College Closed
Thanksgiving Day	November 23	Holiday
Day after Thanksgiving	November 24	College Closed
Winter Break	December 22–January 1	College Closed
Christmas Day	December 25	Holiday

Employees have also been granted three (3) Personal Days to be used throughout the year for personal needs and for the observance of days of personal significance that are not reflected in the calendar.

Any hourly employee who works on a holiday will be paid for the holiday and will also be paid for working on the holiday. Part-time employees will be paid for a holiday if they are regularly scheduled to work on that day.

Endicott Benefits At-A-Glance

Retirement Plan

We value the hard work and commitment you show towards the Endicott College community, and want to help ensure financial security after your employment here is over. Our generous retirement plan is offered to full-time (35+ hours per week) employees.

The Endicott Employee Retirement Plan is governed by section 403(b) of the Internal Revenue Code and is administered by TIAA. The Plan lets you save your own money for your retirement in a tax-advantaged way and allows the College to contribute as well. If you are in a faculty or staff role and participate in the Plan, the College will contribute up to 8% of your pay to your retirement account.

- You may begin contributing your own money, via payroll deduction, upon your date of hire.
- You may contribute any percentage per pay period, but there is an annual limit per IRS guidelines: $22,500 per year if you are under age 50, $30,000 per year if you are age 50 or older.
- Percentage contributions depend on your participation choice:
    - You will be automatically enrolled at a 2% contribution level after one year of full-time employment if you have not already enrolled voluntarily. You may opt out of this if desired.
    - If you make a 2% contribution, the College will make an 8% contribution on your behalf.
    - If you do not make (opt out of) a 2% contribution, the College will contribute 6% of your pay to the retirement plan on your behalf.
- You may change or stop your contribution at any time during the year.
- You have two options for saving in a tax-advantaged way; you may wish to speak with a tax advisor or a TIAA representative to decide which option is best for you:
    - You may save before payroll taxes are calculated (pre-tax), which reduces your tax liability for the current year. You will pay taxes on your savings plus earnings later, when you withdraw from your account.
    - After federal and state taxes are calculated, you may save to a Roth 403(b) account. That means you will pay taxes now but your savings plus earnings are tax-free when withdrawn.
- You must create an account with TIAA in order to direct your contributions and to name your beneficiaries. If you do not create an account, your contributions and the College's contributions will be automatically directed to a Lifecycle fund with TIAA.

Medical Insurance

All medical insurance benefits are provided through Blue Cross Blue Shield of Massachusetts. You have two options for health insurance:

HMO Value Plus – an HMO plan that requires you to use an in-network provider. You must choose a primary care physician (PCP) and obtain referrals for specialty care.

- No deductible or co-insurance is required.
- Most services require a copayment at time of visit.
- Annual routine exams are paid at no cost to you.

PPO Saver 3000 – a PPO plan that offers in and out-of-network coverage. You must also pay a deductible before the plan pays for most services. If you choose to go out-of-network, you pay additional out of pocket costs.

- An annual deductible of $3,000 for an individual or $6,000 for a family applies. Endicott will cover half of your out of pocket deductible in the form of a Health Savings Account. **See page 8 for more details.**
- Most services are subject to deductible.
- Annual routine exams are paid at no cost to you.
- Out-of-network coverage has co-insurance and deductibles.

Pharmacy Benefit Services (For both HMO Value Plus & PPO Saver 3000)

- Tiered copayments for prescription drugs. Deductible also applies for the PPO plan.
- Coverage is available for a wide variety of medications, with many low-cost generics.
- Access to thousands of retail pharmacies.
- You may receive a three-month supply of maintenance prescriptions for just one copay.

Dental Plan

Dental insurance benefits are provided through Blue Cross Blue Shield of Massachusetts. It is a preferred provider organization (PPO) dental plan with access to an extensive regional network with thousands of participating dentists.

- No deductible for preventative/diagnostic care which includes cleanings, sealants, space maintainers, and x-rays.
- Calendar year maximum benefit is $1,750 per member.

Vision Plan

Vision Insurance is provided by Blue2020, giving you access to EyeMed's Insight Network for a greater variety of choices and flexibility.

- Coverage for exams, prescription glasses, and contact lenses is available each year.
- Choose independent, national retail, and regional retail providers (LensCrafters, Pearle Vision, Target Optical).

Health Reimbursement Account (HRA)

Employees and dependents enrolled in the BCBS HMO plan qualifies for the HRA Plan.

- The HRA plan reimburses you for up to $1,000 per inpatient hospital admission and up to $500 per outpatient surgery for you or your enrolled dependents.
- There is a $2,000 maximum benefit per family, per plan year.
- You must submit your request for copayment reimbursement to WEX within 90 days of the end of the calendar year in which the hospitalization took place.

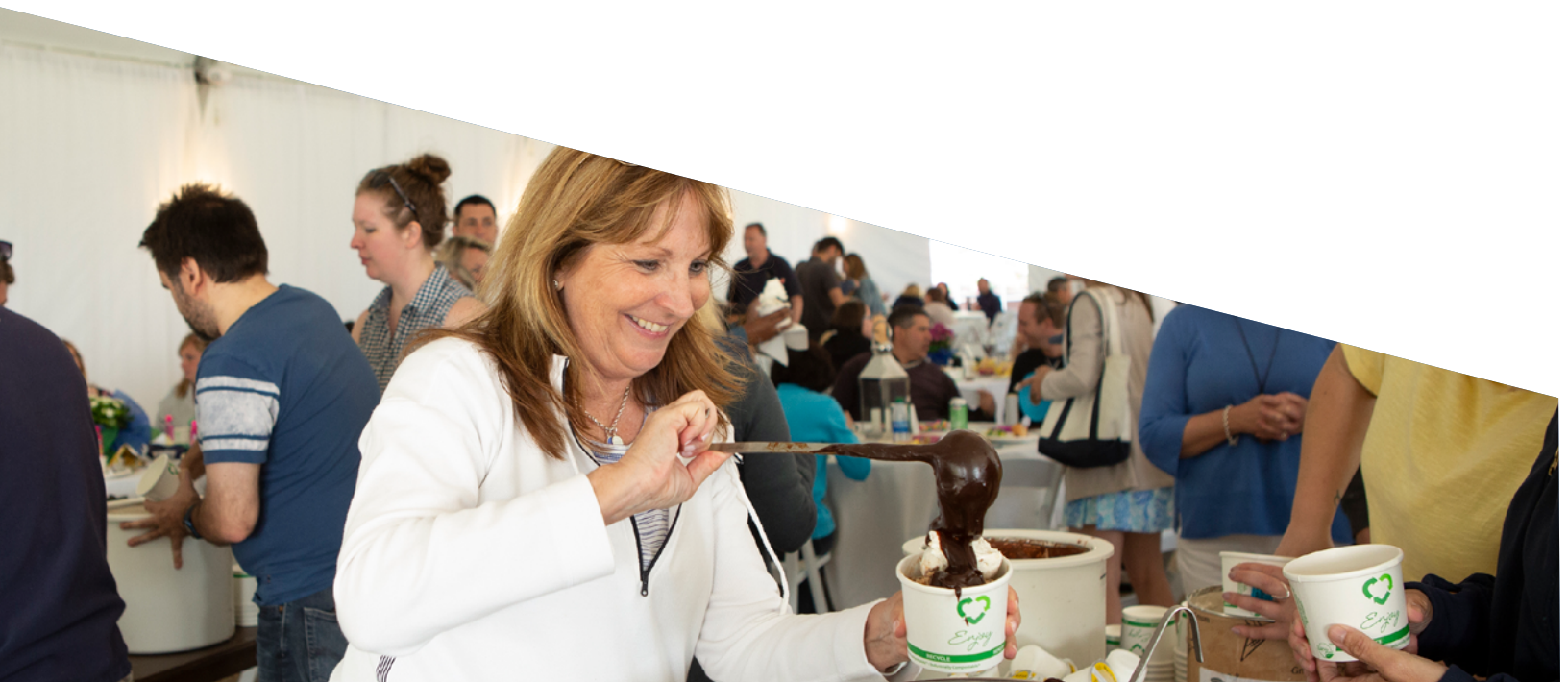
Health Savings Account (HSA)

Employees and dependents enrolled in the PPO Saver 3000 plan qualify for the HSA.
You are eligible to contribute to an HSA unless you are over age 65 and enrolled in Medicare.
The HSA is administered through HealthEquity.

- Endicott will contribute $1,500 per Employee or $3,000 per Employee + 1 or Family annually. The employer contribution will be funded on the election date, prorated on the start date.
- Use your HSA to pay for eligible expenses with tax-free dollars or choose to pay out of pocket and let your HSA balance grow over time.

The IRS Federal limits for HSA contribution in 2023 is:

- $3,850 per Employee
- $7,750 per Family
- Catch up contribution of $1,000 age 55 and over



Flexible Spending Accounts (FSA)

Healthcare FSA

Use pre-tax savings to pay for or reimburse you for qualified out-of-pocket expenses for yourself and your dependents.

- Receive reimbursements for medical care (such as copayments, deductibles, glasses, and laser vision correction), dental expenses (such as orthodontics and expenses over plan allowances), and even over-the-counter products that are health-related (aspirin, sunscreen, lip balm, first aid products, etc.).
- Annual minimum contribution is $200, and annual IRS maximum is $3,050.
- Plan Year is January 1, 2023–December 31, 2023. You must incur all claims by December 31, and submit claims for the 2023 plan year no later than March 31, 2024.
- Any balance remaining in your Healthcare FSA at the end of any Plan Year, up to a maximum $610, will be carried forward and used to fund such benefits in any subsequent Plan Year. This carryover amount will not affect your ability to contribute the maximum amount in the subsequent Plan Year.
- Any remaining balance over $610 will be forfeited.

Limited Purpose Healthcare FSA

- This plan is available for those enrolled in the PPO Saver 3000 only.
- The plan works just like the Healthcare FSA, however, can only be used for Dental and Vision Expenses.
- If you choose to enroll in the PPO Saver 3000 and contribute to a Health Savings Account (HSA), you must spend down any remaining funds in a Healthcare FSA for Plan Year 2022 prior to January 1, 2023.

Dependent Care FSA

Use pre-tax savings for reimbursement of qualified dependent daycare expenses for children up to age 13 incurred while you are working at Endicott.

- The annual minimum contribution is $200, and annual IRS maximum is $5,000.
- The plan Year is January 1, 2023 to December 31, 2023. You must incur all claims by March 15, 2023, and submit claims for the 2023 plan year no later than March 31, 2024.

Tuition Remission

Endicott College offers tuition benefits to its full-time employees and their immediate family members. Graduate programs, on-line courses and programs, institutes and certificate programs are included in tuition remission. Independent studies may be approved for tuition remission at the discretion of the Provost. The benefit covers 100% of the cost of tuition. You are responsible for any fees, including application fees, registration fees, books, materials, and any other course expenses. Please visit MyEndicott for further details.

Insurance Coverage

Basic Life Insurance

Basic life insurance provides a cash benefit to your beneficiary/beneficiaries in the event of your death while employed by Endicott College.

- Endicott provides this benefit at no cost to you.
- Basic life insurance is equal to your annual salary, up to a maximum of $200,000.
- Benefits are reduced starting at age 65, and by age 70 your basic life insurance is equal to 50% of your salary up to a maximum of $100,000.
- Premiums the College pays on coverage over $50,000 of insurance is taxable income and appears on your pay slip as Group Term Life.
- Benefits are tax-free to the beneficiary.
- Upon termination of employment, you may continue this policy at your own expense.
- **Be sure to update your beneficiary/beneficiaries in ADP.**

Accidental Death & Dismemberment Insurance

Accidental Death & Dismemberment (AD&D) insurance provides an additional cash benefit to your beneficiary/beneficiaries in the event of your accidental death and to you if you lose a limb or part of a limb, if either occurs while employed by Endicott College.

- Endicott provides this benefit at no cost to you.
- AD&D insurance is equal to your annual salary up to a maximum of $200,000.
- Benefits are reduced starting at age 65, and by age 70 your basic life insurance is equal to 50% of your salary up to a maximum of $100,000.

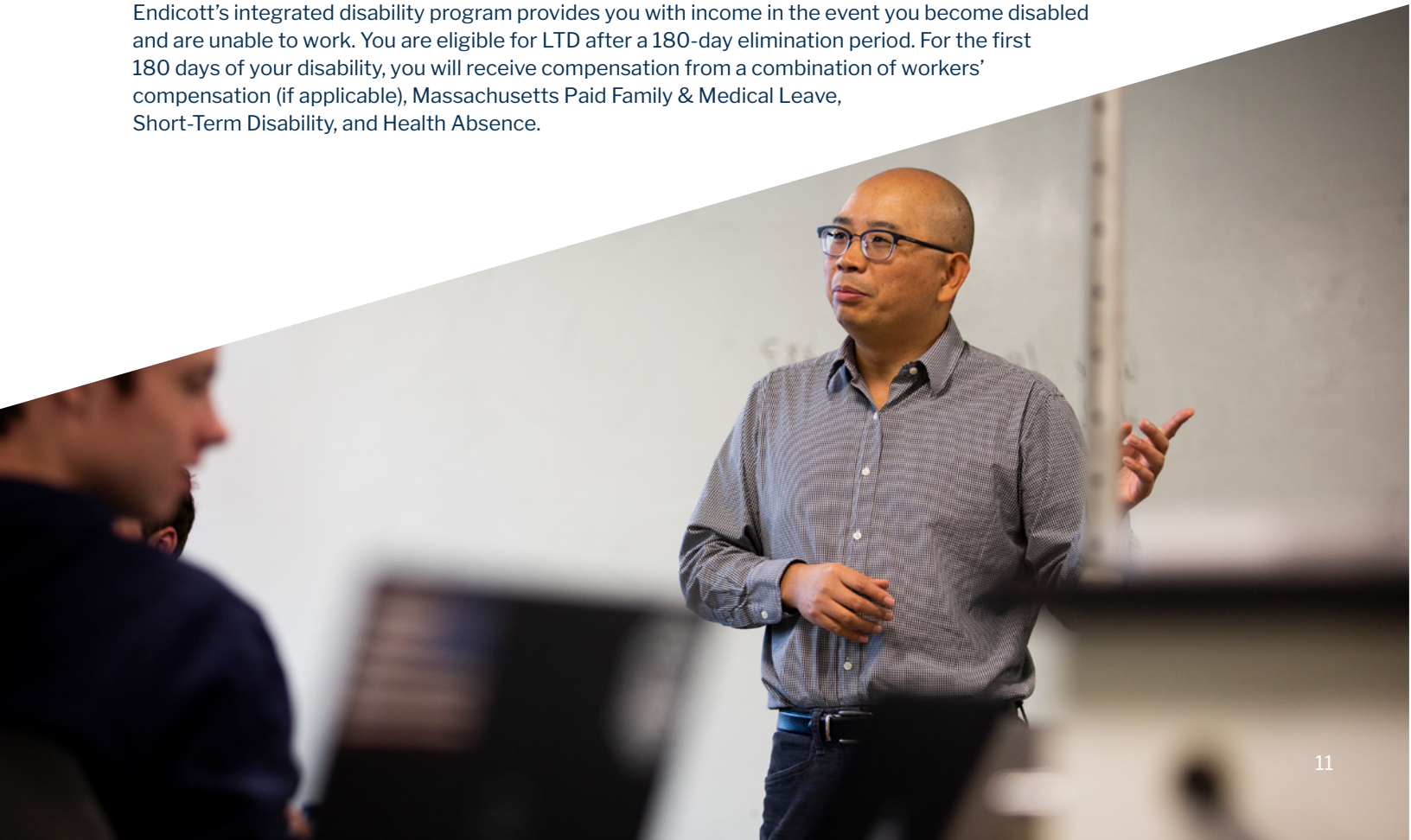
Supplemental Life and AD&D Insurance

You may **purchase** additional life insurance and AD&D insurance at preferred rates through the convenience of payroll deductions.

- You may elect coverage between one and five times your annual salary, up to $200,000.
- You are eligible for the guaranteed issue amount up to $180,000 if enrolled within 30 days of hire. Evidence of Insurability (EOI) is required over $180,000. During this enrollment period, employees are able to enroll or increase their Supplemental Life insurance coverage up to the $180,000 guarantee issue amount without medical underwriting (EOI) required, for a 1/1/23 effective date. Outside of this enrollment period, EOI is required for any new or increased coverage that is elected.
- You need to provide EOI if you wish to increase coverage by more than 1x your salary.
- You may elect coverage for your spouse up to $50,000.
- Your spouse is eligible for the guaranteed issue amount up to $30,000 if enrolled within 30 days of hire. Evidence of Insurability (EOI) required over $30,000. During this enrollment period, employees are able to enroll or increase their spouse's amount of Supplemental Life insurance coverage up to the $30,000 guarantee issue amount with medical underwriting (EOI) required, for a 1/1/23 effective date. Outside of this enrollment period, EOI is required for any new or increased coverage that is elected.
- Spouses are eligible for up to 100% of the employee's Supplemental Life amount (subject to the $50k maximum).
- You may reduce or increase your coverage during the open enrollment period.
- You may continue this policy at your own expense upon termination of employment.
- **Be sure to update your beneficiary/beneficiaries in ADP**.

Long-Term Disability Insurance (LTD)

Endicott's integrated disability program provides you with income in the event you become disabled and are unable to work. You are eligible for LTD after a 180-day elimination period. For the first 180 days of your disability, you will receive compensation from a combination of workers' compensation (if applicable), Massachusetts Paid Family & Medical Leave, Short-Term Disability, and Health Absence.



Leaves & Absence

Health Absence

Endicott provides you with sick time, which is referred to as **Health Absence (HA)**. The intent of offering this time is to help employees and their families maintain wellness, not just to take time when sick.

Health Absence time is available for you to use for occasional personal illness not covered by Paid Medical Leave or Short-Term Disability, or to attend routine medical or dental appointments. You may use up to 40 hours per year of Health Absence time to care for a family member or to accompany a family member to routine medical or dental appointments.

Protecting Your Income During Parental & Medical Leaves

If you have a serious medical condition, have a baby, or welcome a foster or adopted child into your family, Endicott has programs to protect your income while on leave. Some of these are familiar to you, such as Health Absence and Short-Term Disability. The College is pleased to also offer Paid Medical Leave (PML) for those who are eligible. This benefit is only available to employees who work in Massachusetts.

Paid Medical Leave (PML) is an insurance Endicott has purchased to ensure compliance with the Massachusetts Paid Family & Medical Leave law.

- Endicott now provides you with Paid Medical Leave. You will receive a percentage of your pay, based on a calculation using your actual pay over the last four quarters and the average weekly pay across the Commonwealth of Massachusetts. Endicott continues to provide you with **Short-Term Disability (STD)**. If PML does not provide you with 60% of your base salary, STD will supplement PML to a maximum of $1,000 per week.
- You may use Health Absence time to continue pay during the waiting period.
- Both PML and STD are available after a seven (7) day waiting period.

Endicott continues to provide federal Family & Medical Leave Act (FMLA) coverage. FMLA protects your job for up to 12 weeks for your or a family member's serious medical condition. It does not provide any type of salary continuance. In almost all circumstances, the policies described above provide the same or more job protection and also provide some level of income.

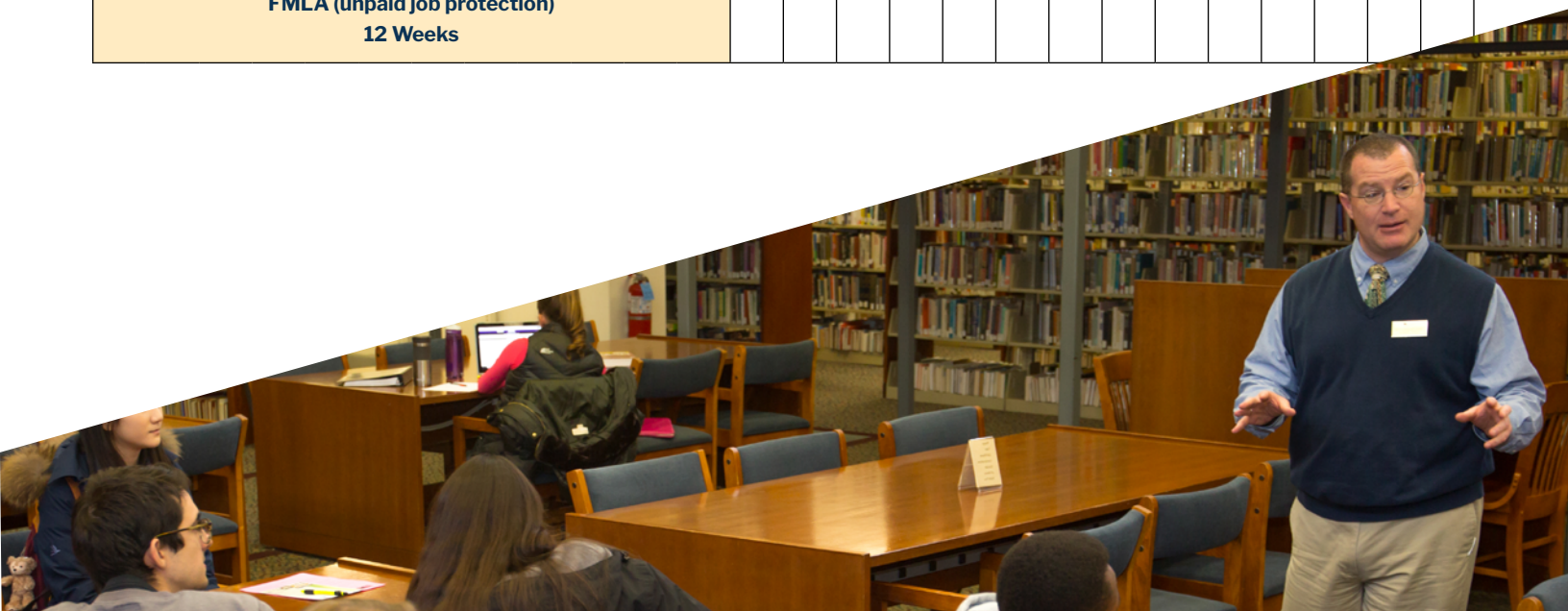
Please see the chart on the next page to see how these benefits fit together.

Weeks of Leave – Birth or Placement of Foster or Adopted Child

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
HA																	
	Paid Medical Leave (birth mother) 5 Weeks																
	Short-Term Disability 5 Weeks																
						Paid Bonding Leave (birth mother) 12 Weeks											
	Paid Bonding Leave (non-birth parent) 11 Weeks																
FMLA (unpaid job protection) 12 Weeks																	

Weeks of Leave – Your Own Serious Medical Condition

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
HA																									
	Paid Medical Leave 19 Weeks																								
	Employer's Short-Term Disability (for employee) 25 Weeks																								
FMLA (unpaid job protection) 12 Weeks																									



Medical

View the enrollment site and benefits e-kit for more information.

Summary of Plan Description		BCBS MA HMO Blue NE Value Plus		BCBS MA PPO Saver 3000	
		In-Network		In-Network	
Deductible (Single / Family)		N/A		$3,000 / $6,000	
Coinsurance		N/A		N/A	
Out-of-Pocket Max (Single / Family)		$2,000 / $4,000		$6,450 / $12,900	
Office Visit (PCP – Specialist)		$20 / $35		Subject to Deductible	
Preventive Care		No Charge		No Charge	
Hospitalization		$1,000 Copayment		Subject to Deductible	
Out Patient Surgery		$500 Copayment		Subject to Deductible	
Rehabilitation & Habilitation Services		$35 Copayment		Subject to Deductible	
Laboratory		No Charge		Subject to Deductible	
Radiology		No Charge		Subject to Deductible	
High Cost Diagnostics		$75 Copayment		Subject to Deductible	
Emergency Room		$150 Copayment		$150 Copy after Deductible	
Durable Medical Equipment		No Charge up to $750		20% Coins. after Deductible	
		In-Network		Out-of-Network	
Deductible		N/A		$3,000 / $6,000	
Coinsurance		N/A		20%	
Out-of-Network Maximum with Ded.		$2,000 / $4,000		$6,450 / $12,900	
Prescription Drugs		Retail	Mail Order	Retail	Mail Order
	Deductible	N/A	N/A	Combined with Medical	Combined with Medical
	Generic	$15	$15	$10	$20
	Preferred Brand	$30	$30	$25	$50
	Non-Preferred Brand	$50	$50	$45	$135
	Preferred Specialty	$75	$75	Applicable cost share	N/A
	Non-Preferred Specialty	$100	$100	Applicable cost share	N/A
	Mandatory Generic	Dispense as Written		Dispense as Written	
	Rx Out-of-Pocket Maximum	Combined with Medical		Combined with Medical	

Dental

Summary of Plan		BCBS MA Dental Blue 2	
		In-Network	Out-of-Network
Deductible (Waived For Preventive)			
	Individual	$25	$25
	Family	$75	$75
Annual Maximum		$1,750	$1,750
Diagnostic & Preventive			
	Exams	100%	100%
	Cleanings	100%	100%
	Flouride	100%	100%
	Space Maintainers	100%	100%
	X-Rays	100%	100%
	Sealants	100%	100%
Basic Services			
	Emergency Treatment for Pain	80%	80%
	Fillings, Stainless Crowns	80%	80%
	Endodontics (Root Canal)	80%	80%
	Periodontics (Gum Disease)	80%	80%
	Simple Extractions	80%	80%
	General Anesthesia	80%	80%
Major Services			
	Crowns, Inlays, Outlays	50%	50%
	Bridges and Dentures	50%	50%
	Repairs and Adjustments	50%	50%
Orthodontics			
	Benefit Percentage	N/A	
	Lifetime Maximum	N/A	
	Age Limitation	N/A	
Dependent Eligibility			
	Dependents Eligible to Age	26	
	Full-Time Students to Age	26	

Vision

Summary of Plan Description		BCBS Blue 20/20 Vision	
		In-Network	**Out-of-Network**
Comprehensive Eye Exam		$10 Copay	Up to $50
Contact Lens Fit and Follow-Up			
	Standard	Up to $55	N/A
	Premium	$20 / $35	N/A
Retinal Imaging		Up to $39	N/A
Frames		$130 Allowance, then additional 20% off balance	Up to $74
Standard Plastic Lenses			
	Single Vision	$25 Copay	Up to $42
	Bifocal	$25 Copay	Up to $78
	Trifocal	$25 Copay	Up to $130
	Lenticular	$25 Copay	Up to $130
	Standard Progressive	$90 Copay	Up to $140
Contact Lenses (in lieu of glasses)			
	Conventional	$130 Allowance, then additional 15% off balance	Up to $104
	Disposable	$130 Allowance	Up to $104
Frequency			
	Exams	Once Every 12 Months	
	Lenses or Contacts	Once Every 12 Months	
	Frames	Once Every 24 Months	
Network		Independent Retailers and Retail Providers include: LensCrafters, Pearle Vision, Sears, Target & J.C. Penney	

2023 Medical Rates		
Employee Biweekly Contribution		
	Blue NE VP	PPO Saver 3000
EE	$93.97	$75.00
EE+1	$238.33	$190.19
Family	$259.38	$206.99

2023 Dental Rates	
Employee Biweekly Contribution	
Dental Blue	
Employee	$4.02
Family	$11.68

2023 Vision Rates	
Employee Biweekly Contribution	
Blue 20/20	
Employee	$3.41
Family	$8.95

Payroll & Time Off Requests

Pay Period

Our payroll processes on a biweekly basis with a check date of the Friday following the end of the pay period.

ADP & Payroll

Endicott uses ADP for payroll and human resource functions. You will use ADP throughout your Endicott career for onboarding and self-service functions.

You have access to your pay statements and annual W2 through ADP; navigate to the Myself>Pay>Pay Statements. The Myself tab can also be utilized to update your direct deposit or tax withholding information.

If you are an hourly employee, you will also use ADP to record your time under Myself>Time>Attendance>My Timecard.

Time Off Requests

All of your time off requests will be processed in ADP. You must navigate to Myself>Time Off>Time Off Requests.

Provider Contact Information

For detailed benefit information, visit the websites of our providers.

Blue Cross Blue Shield
bcbsma.com | 800-262-2583

HealthEquity
(Health Savings Account)
bluecrossma.com/myblue or myhealthequity.com | 866-346-5800

BCBS Dental
bcbsma.com | 800-262-2583

WEX
(Flexible Spending Accounts & Health Reimbursement Accounts)
discoverybenefits.com | 866-451-3399

Unum
unum.com | 866-679-3054

Blue 20/20 Vision
bluecrossma.com | 800-262-2583

Compliance Notices

Endicott College

376 Hale Street, Beverly, MA, 01915
Cindy Larkin, Plan Administrator, (978) 922-2026

Effective Date: October 06, 2022

Employee & Eligible Beneficiaries,

As an employee of Endicott College and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Cindy Larkin, Endicott College at: (978) 922-2026
For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE
Medical Plan: Blue Cross Blue Shield of MA

About Your Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage 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. We have determined the prescription drug coverage offered by Blue Cross Blue Shield of MA is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.
Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage 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 the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.

The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.

PHI refers to individually identifiable health information received by the company’s group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.

The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.

Company records that are governed by this policy will be maintained for a period of no less than six years.

Questions or issues regarding PHI should be addressed with Human Resources.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA
The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation
If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this

law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law
Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.
If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law
The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)
QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the

administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

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

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person’s health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee’s coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee’s coverage may be cancelled prospectively but not retroactively.

Should a member’s coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member’s appeal rights as required by law and as provided in the member’s plan benefit documents. Please be aware that if you rescind a member’s coverage, you must provide the proper notice to the member.

PREVENTIVE CARE

Health plans through Blue Cross Blue Shield of MA will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

WOMEN'S PREVENTIVE HEALTH SERVICES
All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through Blue Cross Blue Shield of MA:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

PATIENT PROTECTION
Blue Cross Blue Shield of MA generally requires or 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. To designate your primary care provider contact Blue Cross Blue Shield of MA at (800) 262-2583

Until you designate a primary care provider, Blue Cross Blue Shield of MA may designate one for you. For children, you may have the ability to designate a pediatrician as the primary care provider as defined in component plan documents.

You may not need prior authorization from Blue Cross Blue Shield of MA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. See Component Plan Documents for details.

FMLA
The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

MHPA/MHPAEA
Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

COBRA NOTICE
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a dependent child.

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

For all other qualifying events (divorce, or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

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

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

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Extension of Certain Timeframes due to the COVID-19 Emergency
On February 26, 2021, the US Department of Labor announced that, due to the ongoing national emergency caused by the COVID-19 outbreak, certain timeframes required under ERISA and the IRS have been extended. These dates were further clarified by IRS Guidance 2021-58 in October 2021. Specifically, applicable deadlines that fall within the Outbreak Period are extended until the earlier of: (i) the one-year anniversary of the otherwise applicable deadline, or (ii) sixty (60) days after the end of the Outbreak Period. This applies to deadlines applicable to individuals participating in the plan, as well as deadlines applicable to the plan and plan administrators. The deadline extension period is determined on an individual-by-individual or case-by-case basis.

The actual date the compliance timeframe resumes will depend on the date the National Emergency is declared to be over by the Federal Government.

The timeframes for the following plan conditions are extended by this Final Rule:

- HIPAA Special Enrollment Periods ("COBRA Qualifying Events")
- COBRA Election periods
- The date for making COBRA premium payments
- The date for qualified beneficiaries to notify the COBRA administrator of a qualifying event or a determination of disability
- The date for filing a benefits claim
- The date for filing an appeal of an adverse benefit determination
- The date for requesting an external review of an adverse benefit determination
- The date for filing a corrected request for external review, in the event the initial request was incomplete.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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

MASSACHUSSETTS PARTIAL PROTECTIONS AVAILABLE:

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of out-of-network health care professionals
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities
    - enrollees who consent to out-of-network services*
    - enrollees of self-funded plans

Notes:

* Protections for non-emergency or emergency services do not apply if:

- an in-network provider is available

- and enrollee has "reasonable opportunity" to choose to have the service performed by a network provider.

Referenced from https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

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

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

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

MASSACHUSSETTS PARTIAL PROTECTIONS AVAILABLE:

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of out-of-network health care professionals
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities
    - enrollees who consent to out-of-network services*
    - enrollees of self-funded plans

Notes:

* Protections for non-emergency or emergency services do not apply if:

- an in-network provider is available

- and enrollee has "reasonable opportunity" to choose to have the service performed by a network provider.

Referenced from https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

When balance billing isn't allowed, you also have the following protections:

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

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download for more information about your rights under Massachusetts.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Endicott College

376 Hale Street, Beverly, MA, 01915
Cindy Larkin, Plan Administrator, (978) 922-2026

Effective Date: October 06, 2022

HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.

The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.

PHI refers to individually identifiable health information received by the company’s group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.

The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.

Company records that are governed by this policy will be maintained for a period of no less than six years.

Questions or issues regarding PHI should be addressed with Human Resources.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA
The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation
If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law
Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.
If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law
The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)
QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to

determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

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

EORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

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

To see if any other states have added a premium assistance program since July 31, 2022, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

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

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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

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Employee Benefits Enrollment Guide

2023

ENDICOTT COLLEGE