Ursinus College



2024-2025 PLAN YEAR

EMPLOYEE BENEFITS PACKAGE

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Benefit Information

WHAT IS CHANGING FOR THE UPCOMING YEAR?

The upcoming year will be a ***short-plan year,*** with the benefits beginning November 1, 2024 and ending June 30, 2025. The benefits will renew on a July 1 basis moving forward.

- **Benefit Broker:** Ursinus College has partnered with a new benefit broker for this year's upcoming benefits - Exude! Through Exude, you have a dedicated Client Care Specialist that can help answer questions related to this year's upcoming plans.
- **Medical**: Medical coverage will change to Meritain using the Aetna network of providers with 3 plans.
  - **Teladoc**: If enrolled into medical, you will have access to Teladoc.
- **HRA/HSA/FSA**: HRA, HSA, and FSA Administration will remain with The Harrison Group.
  - **HRA**: Due to the short plan year, the College will be increasing the HRA funding for this upcoming plan year ***only***.
  - **HSA**: A health savings account can be paired with the Bronze or Silver Medical Plans. The College will contribute up to $350 to your HSA if enrolled into the Bronze or Silver Plan.
  - **FSA**: Prorated maximum contribution limits due to the short plan year.
- **Dental**: Dental coverage will change to MetLife; enhanced benefits available.
- **Vision**: Vision coverage will remain through VBA with a Base Plan (tied to medical enrollment) or Voluntary Buy-Up plan.
- **Life/AD&D, Voluntary Life/AD&D, Long Term Disability, and EAP**: Coverage will change to Mutual of Omaha.

Please note that the following service will no longer be available beginning November 1, 2024:

- **Sanctuary Counseling**: This counseling service is being discontinued, however there are new programs outlined below that provide access to behavioral health services.
  - **Medical Plan Enrollees**: If enrolled into a Meritain medical plan, you will be eligible for virtual behavioral health services via Teladoc.
  - **All Benefit-Eligible Employees**: Access to Mutual's Employee Assistance Program (EAP) which provides access to 3 counseling sessions per year, per household, conducted by either face-to-face visits or video visits.

NEW HIRE WAITING PERIOD

Full-time employees who work 30 hours per week or more are eligible for benefits. Employees who begin their employment on the 1st of the month immediately qualify for benefits on that day. Employees who begin after the 1st of the month will qualify for benefits on the 1st of the following month.

ELIGIBLE DEPENDENTS

Eligible dependents include your spouse or domestic partner and children under the age of 26. Dependent children will be removed from coverage at the end of the calendar year in which they turn 26.

OPEN ENROLLMENT: SHORT PLAN YEAR

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during the open enrollment period each year. All changes made during this time period will take effect on the plan renewal date. The upcoming plan year will be a short plan year and will run from November 1, 2024 through June 30, 2025. All subsequent plan years will run on a July 1 through June 30 plan year.

QUALIFIED LIFE EVENTS

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. You must report this change and submit the necessary documentation within 31 days of your Qualifying Event in order to make a change.

TRANSITION OF CARE

If you are currently in the middle of treatment or if you have a scheduled procedure on or after November 1, 2024, please connect with your Exude Client Care Specialist, Angie Sotomayor, for assistance with transition of care.

HAVE QUESTIONS ABOUT YOUR BENEFIT PLAN OPTIONS?

You have a dedicated Client Care Specialist from Exude that can help assist with benefit-related inquiries for the upcoming year's plans. Please contact: Angie Sotomayor from Exude at asotomayor@exudeinc.com or by calling 215-422-4790. You can also schedule a 1x1 benefits consultation with Angie by visiting Calendly.

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Meet Your Client Care Specialist

Angie Sotomayor

Meet Angie, she's your dedicated Client Care Specialist. Angie's ready to support your benefit issues from start to finish, so if you ever have questions or forget to mention something along the way, just call her. Angie will fight for what is right on your behalf. You can reach our on-call team for **urgent issues** 24/7 at 215.875.8730.

SCAN ME

To add me to your contacts

Angie can help you with:

1 **BENEFIT QUESTIONS**

Confused about what procedures or medications are covered under your plan? Give us a call and we'll lay it out for you.

2 **CLAIMS ISSUES**

Receive an unexpected or confusing medical or dental bill? Send it to your advocate and they will research, resolve, and explain any issues.

3 **OTHER WAYS WE CAN HELP**

- Verifying active coverage if you are stuck at your doctor or pharmacy
- 24/7 Service – When you have an urgent concern about your benefit, our team is available around the clock for your questions.

Get In Touch

asotomayor@exudeinc.com

(p) 215.422.4790
(f) 215.875.8785

Click Here to Schedule a 1x1 Consultation
(Or visit www.calendly.com/exude_angie)

EXUDE

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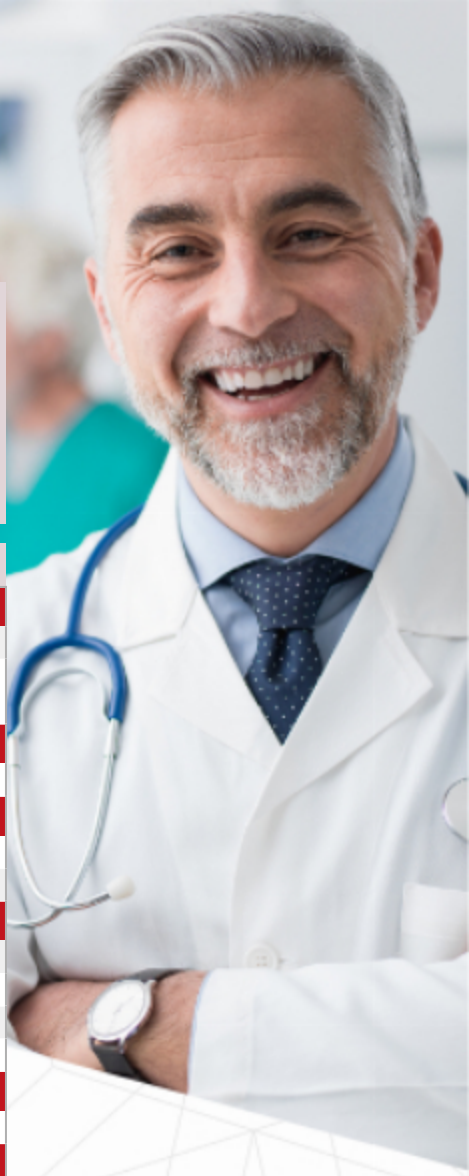
Medical Plans



Plan Explanation

Meritain is the Third Party Administrator that will administer the medical plans effective November 1, 2024. Providers should submit all claims to Meritain for processing. Aetna is the plan network that is being utilized. All three medical plans include access to Teladoc for on-demand general medical consultations, tele-behavioral health visits, and tele-dermatology visits.

	Meritain | Bronze	**Meritain** | Silver	**Meritain** | Gold
DEDUCTIBLE	IN-NETWORK	IN-NETWORK	IN-NETWORK
Single (Employee Only)	$4,000	$2,500	$1,000
Family (Employee/Spouse, Employee/Child(ren), Employee/Family)	$8,000	$5,000	$2,000
COINSURANCE AFTER DEDUCTIBLE			
Plan & Member Coinsurance	Plan 90%; Member 10%	Plan 100%; Member 0%	N/A
OUT OF POCKET MAXIMUM			
Single	$6,350	$6,350	$6,350
Family	$12,700	$12,700	$12,700
COMMONLY USED SERVICES			
Primary Care Physician Office Visit	10% After Deductible	No charge after deductible	$20
Specialist Office Visit	10% After Deductible	No charge after deductible	$40
Urgent Care	10% After Deductible	No charge after deductible	$50
Emergency Room	10% After Deductible	No charge after deductible	$150
PREVENTIVE CARE			
Preventive Services	Covered 100%	Covered 100%	Covered 100%
MAJOR MEDICAL EXPENSES			
Outpatient Surgery	10% After Deductible	No charge after deductible	$75 After Deductible
Inpatient Hospitalization	10% After Deductible	No charge after deductible	$150 Per Day; 5 Day Copay Maximum After Deductible
Complex Imaging	10% After Deductible	No charge after deductible	$150
PRESCRIPTION DRUG COVERAGE			
Generic (Tier 1)	$5 After Deductible	$5 After Deductible	$5
Brand Name (Tier 2)	$20 After Deductible	$20 After Deductible	$20
Non-Preferred (Tier 3)	$45 After Deductible	$45 After Deductible	$45
CVS Caremark Formulary	Standard Control w/ ACSF	Standard Control w/ ACSF	Standard Control w/ ACSF
PLAN INFORMATION			
Plan Year	11/1/2024 - 6/30/2025	11/1/2024 - 6/30/2025	11/1/2024 - 6/30/2025
Deductible Period	Plan Year	Plan Year	Plan Year
Deductible Explanation	Embedded	Non-Embedded Aggregate	Embedded
Provider Network	aetna.com/dsepublic/#/mymeritain	aetna.com/dsepublic/#/mymeritain	aetna.com/dsepublic/#/mymeritain
Network Name	Aetna Choice POS II (Open Access)	Aetna Choice POS II (Open Access)	Aetna Choice POS II (Open Access)
Out of Network Deductible	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $15,000
Out of Network Coinsurance	50%	50%	50%

MONTHLY PREMIUM COST			
Employee Only	$24.48	$44.95	$194.44
Employee + Child(ren)	$225.86	$320.15	$412.25
Employee + Spouse	$289.42	$335.79	$594.20
Family	$370.56	$512.74	$1,098.59

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Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your Summary Plan Description.

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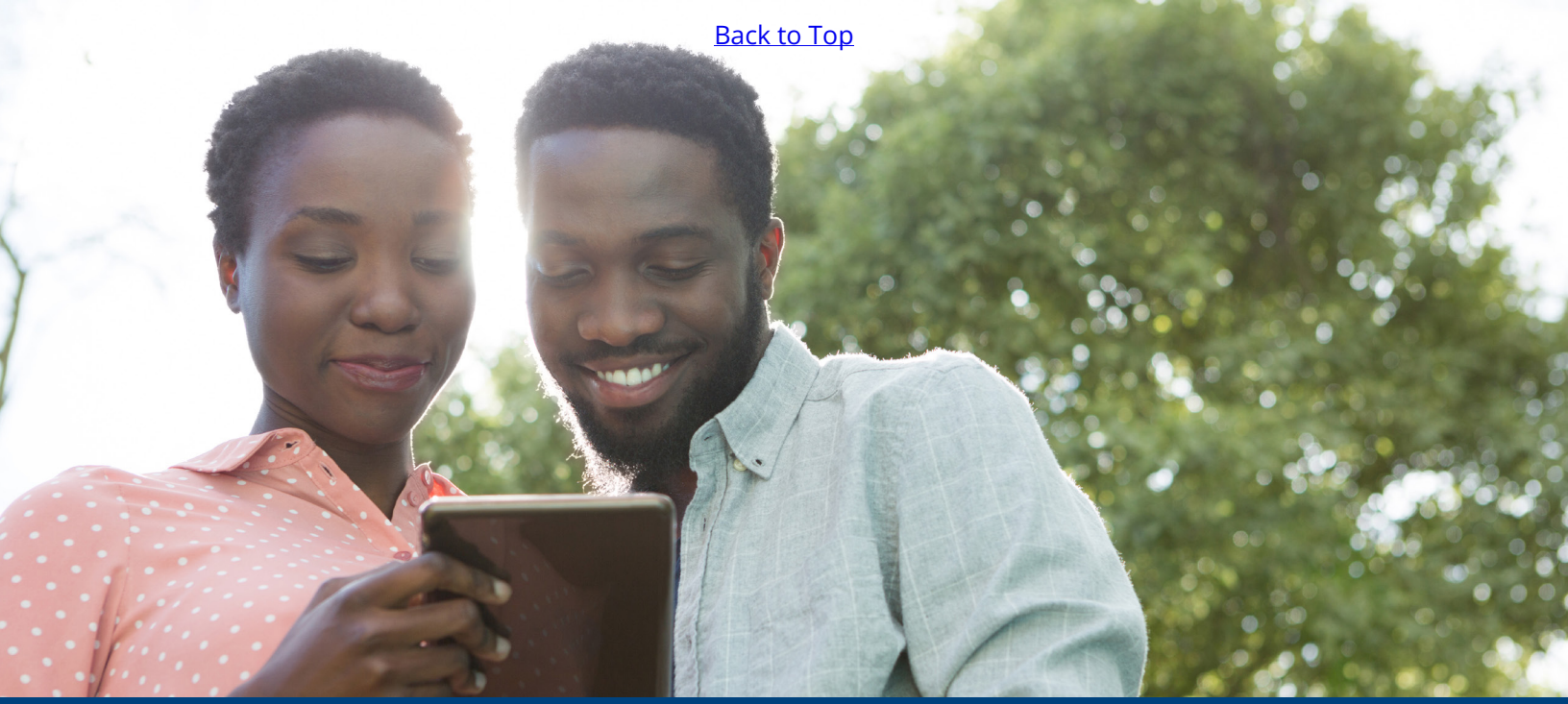

Your Member Website

What you'll find on the Meritain Health® member website

Using the Meritain Health member website, you have 24-hour access to a number of tools and resources that can help you manage your health benefits. Below are a few things you can do on **meritain.com**:

- Verify eligibility and benefits coverage
- Find the status of claims
- Access your ID card (view, print or request new cards)
- Submit a claim for reimbursement directly to you
- View your Explanation of Benefits (EOB) documents
- Review your benefit plan documents in their entirety
- View deductibles and out-of-pocket limits
- Check Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) balances, if applicable
- Submit Coordination of Benefits (COB) information
- Update user demographic information
- Request Letter of Coverage (LOC)
- Prescription plan coverage
- Update account settings

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Access as easy as 1–2–3!

Step 1:

Open your web browser and go to **www.meritain.com**.

Step 2:

You'll need to register your account. Start by clicking *Register* and then clicking on the *Member tab*.

Your spouse and adult dependents will need to create their own accounts.

Step 3:

You'll need to fill in your:

- Group ID (you can find this on your ID card).
- Member ID (you can find this on your ID card, as well. You should enter it with no spaces or dashes).
- Date of birth.
- Name (as it appears on your ID card).
- ZIP code.

You will be prompted to enter an email address, create a username and password, and select a security question. Review the terms and conditions, and click *I agree to terms and conditions* and *Next*, or click *Cancel*.

The next time you log in, just use the same username and password from Step 3.

Did you know? You have access to a variety of online tools and resources through www.meritain.com!

Questions? Just give us Meritain Health Customer Service a call at the number on your ID card.

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Find Care® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the Find Care online directory from Aetna®. *With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the directory anywhere you have internet access. Just:

1. Visit **https://www.aetna.com/dsepublic/#/mymeritain**.
2. Key in the ZIP code, city, county or state of the desired geographical area in the *Enter location here* field. Click *Search*.
3. Key in *Aetna Choice POS II (Open Access)* under *Select a Plan*. **Or** you can select *Aetna Choice POS II (Open Access)* from the list of plans. Click *Continue.*
4. There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow, choose and click on one of the categories under *Find what you need by category*. **Or see step five.**
5. Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. *What do you want to search for near* (will display your chosen location).
6. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
7. Narrow your search results by using the *Filter & Sort* option. Choices include *Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations* and *Provider Type*.

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Why choose a primary care physician (PCP)?

Meritain Health® does not require you to choose a PCP, but we encourage you to choose one. Your PCP knows your health care needs, so they can help manage your health and coordinate your care. To find and choose a PCP, use the *Find Care* tool on your member website.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 AM–9:00 PM ET, Monday through Friday.

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

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Teladoc® HEALTH

Reach a doctor 24/7

General Medical Solution

Teladoc Health™ is the on-demand health care solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions, including dermatology and behavioral health.

Benefits of using Teladoc Health

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- More peace of mind

With Teladoc Health, you can talk to a doctor 24/7/365 by phone, video or on the mobile app. It can be a great choice for medical advice and care when:

- Your primary care doctor is not open.
- You're at home, traveling or don't want to take time off work to see a doctor.
- You need a prescription or refills*.
- You have behavioral health concerns.

*Please note, there is no guarantee you will be prescribed medication.

Refer to your summary plan description (SPD) for information on behavioral health and general health copays.

Highly qualified, experienced doctors

When you use Teladoc Health, your medical questions will be answered by a highly qualified doctor. Teladoc Health doctors are:

- U.S. board-certified and state-licensed.
- Specially trained in telemedicine.
- Experienced, with an average of over 10–15 years in practice.

Behavioral health services

Taking care of your mental health is an important part of your overall well-being. With Teladoc's Behavioral Health, adults 18 and older can get care for anxiety, depression, grief, family issues, and more. Choose to see a psychiatrist, psychologist, social worker, or therapist and establish an ongoing relationship.

Healthy skin starts here

If you have a skin condition of concern, you shouldn't need to wait for treatment. And now you don't have to! With the addition of Teladoc Dermatology care, you get easy and convenient access to on-demand skin care, and no longer need to wait for an appointment. With Teladoc Dermatology, you'll receive a diagnosis and customized treatment plan within two business days or less.

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Common conditions treated include:

- Allergies.
- Bronchitis.
- Cold or flu.
- Headaches or migraines.
- Eye or ear infections.
- Skin irritations and rashes.
- Respiratory infections.
- Sinus infections.
- Stomachache.
- Urinary tract infections.
- Many other conditions.

More than one way to reach a doctor

By phone. Just call **1.800.835.2362**.

Online. Simply request a video consultation online at **www.Teladoc.com**.

On-the-go. You can download the Teladoc Health mobile app by visiting the App Store® or Google Play™.

Registering for Teladoc Health

You can use Teladoc Health anywhere you have internet access. To get started:

1. Visit **www.Teladoc.com** and click *Set Up Account*.
2. Enter your name, date of birth, ZIP code, email address, preferred language and gender and click *Continue*. The system will identify you based on this information. If you're unable to be identified, you'll be directed to Teladoc Health Customer Service.
3. On the next screen, enter the required information and click *Set up my account*. Your registration is now complete!

Complete your profile by clicking on *My Medical History*. You can enter your history right after registering or come back to finish it later.

If you have any questions, or run into any problems when setting up your account, call Teladoc Health at 1.800.TELADOC (1.800.835.2362).

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Teladoc HEALTH™

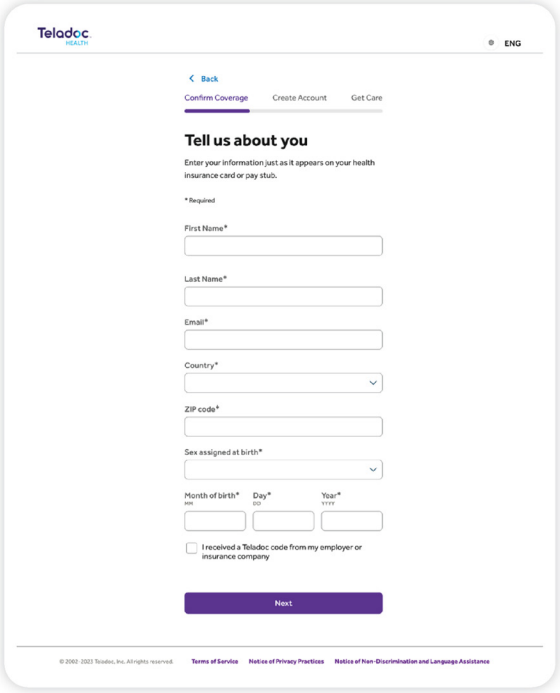
Get started with Teladoc Health™

It's quick and easy to set up your account online. Simply visit the Teladoc Health website, click *Get started* or *Sign up*, and then follow the instructions below.

1. **Confirm benefits.** Provide some information about yourself to confirm your eligibility.

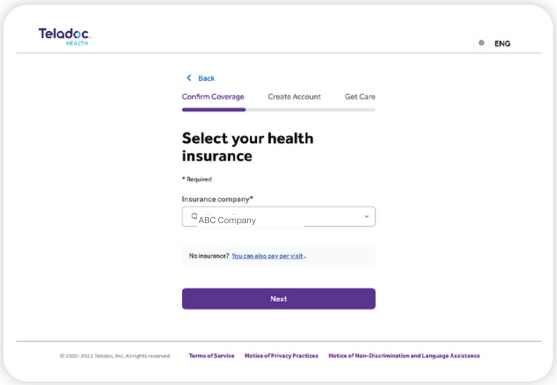
   Please ensure the information you enter matches what is on your Meritain Health® medical ID card.

   Also, do not check the box you have a code from Teladoc Health unless your employer has given you a code.



2. **Select benefit provider.** Pick your health plan from the drop-down menu and enter your health plan ID.

   If you see this screen, please make sure to choose *Meritain Health* from the drop down if your employer does not automatically appear on screen. Or you will see the screen below.



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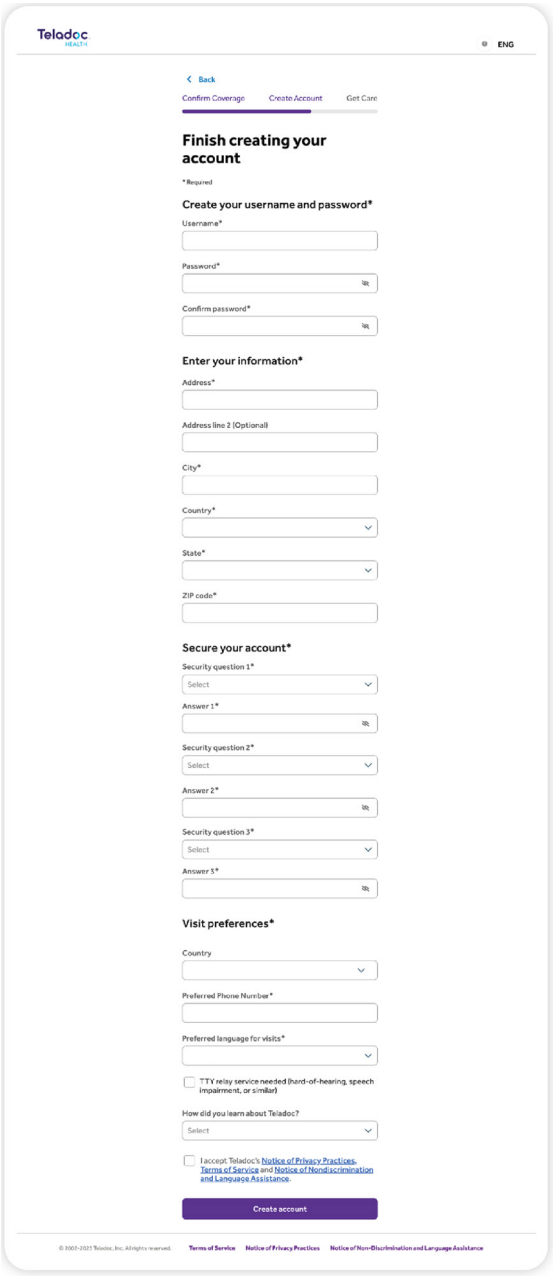

3. **Create account.** Enter your contact information, username, password and security questions.

Once your account is created, eligible dependents under 18 years of age can be added in your account settings under the primary member. Dependents older than 18 should follow the steps above to create their own account.

Get started today

Visit **TeladocHealth.com**, call **1.800.835.2362** or download the app.

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minute clinic®

MinuteClinic® Benefit

Access to MinuteClinic at little to no cost* to you

High-quality care that's affordable and reliable

MinuteClinic makes it easy for you to get the care you need, when and where you need it. And now you can access all eligible services, including general medical MinuteClinic Virtual Care visits at any in-network MinuteClinic at little to no cost* to you.

MinuteClinic including MinuteClinic within a HealthHub, is a walk-in clinic inside select CVS Pharmacy and Target Stores and is the largest provider of retail health care in the United States—with over 1,100 locations in 35 states and District of Columbia**.

It's open every day, including evenings. MinuteClinic offers walk in, scheduled appointments at their brick-and-mortar locations, and MinuteClinic Virtual Care.

MinuteClinic health care providers treat a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.

MinuteClinic Virtual Care provides eligible general medical services as a virtual visit option available seven days a week.

All behavioral health services through MinuteClinic locations and MinuteClinic Virtual Care are not a part of the MinuteClinic benefit and are subject to any applicable cost share and limitations. See benefit plan documents for details.

*Eligible members enrolled in high-deductible plans must meet their deductible. However, such services would be subject to negotiated contract rates. Once the deductible has been met, members will be able to access MinuteClinic services at no cost-share. Members in Aetna Whole Health ACO, APCN Plus, HMO and indemnity plans may not be eligible for this benefit. Such members should refer to their benefit plan documents in order to determine coverage and applicable cost-share for walk-in clinic benefits and services, as applicable.

Meritain Health, Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are within the CVS Health family. Meritain Health is not responsible or liable in any manner for services received at CVS MinuteClinic locations.

**Visit cvs.com/minuteclinic for age and service restrictions. This is for informational purposes only. It is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Information is believed to be accurate as of the production date; however, it is subject to change. Includes access to all covered services at MinuteClinic.

Questions? Just call Meritain Health® at the number located on the back of your ID card.

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Claim Your Wellness Savings

Your nationwide deals await

LifeMart® Employee Discount Program

Browse big savings on major brands for all your health and wellness needs. LifeMart is your employer's way of saying thanks for your hard work— and helping you keep more of your paycheck.

Access LifeMart anywhere, anytime, on any device. It's the fast and easy way to:

- Save money on all your health and wellness needs—from gyms, to diet plans, groceries and everything in between.
- Access offers personal wellness products and services—LifeMart also offers deals on everyday needs such as travel, tickets, car rentals, electronics and more.
- Get deals for the family—such as pet products, child care discounts, products for aging loved ones and more!
- Save time with instant, one-stop shopping—with no need to run out to the store or search the web.
- Have fun discovering exclusive new deals on the brands you love—offers are updated regularly.

Getting Started with LifeMart

Accessing LifeMart is easy. Just complete the online registration by filling out your first name, last name, email address and a password. Once you're registered, you will be able to view and access discounts. Members also have the option to opt-in or out of of email notifications.

There are a few different ways to access LifeMart

1. Through your Meritain Health® member website. Click the *LifeMart* link under *Tools and Resources*, or click the *LifeMart* tile at the bottom of your homepage.
2. By following this link: **http://meritain.lifemart.com**.
3. With the LifeMart mobile app, so you can access LifeMart discounts anywhere, anytime. Simply download the app and you can browse major savings on the go. It's available for download in the Google Play Store™ and iTunes Store®. **Please note:** you'll need to register online to access the LifeMart mobile app.

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Need Help?

You can reach out to our help desk via email for assistance. Just click on the *Need Help* link in LifeMart! The Need Help feature also has commonly asked questions and answers to assist you. You can also use the direct customer support email **helpdesk@lifecare.com**.

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Welcome!

Welcome to your new prescription benefit plan. We will be working with Ursinus College to administer the prescription benefit portion of your health plan.

Your prescription plan offers two ways to get your medications:

- For medications taken for a short time (like an antibiotic), fill anywhere in our network of more than 68,000 pharmacies nationwide, including chain pharmacies, 20,000 independent pharmacies and 9,600 CVS Pharmacy locations (including those inside Target stores).
- For medications taken regularly (such as for high blood pressure or diabetes), get them delivered to your door. To sign up for mail service, choose either option below:
  - Register at Caremark.com/startnow and follow the instructions to request a new 90-day prescription.
  - Call the Customer Care number on the back of your prescription ID card.

Here are some additional services we offer:

- CVS Specialty™ is designed for individuals with rare, complex or genetic conditions. Our specialty pharmacy offers convenient delivery of specialty medications or pickup at CVS Pharmacy*, personalized service and educational support for your specific treatment. CVS Specialty also offers access to a clinical pharmacist anytime for any questions that may come up.
- Specialty Guideline Management (SGM) promotes the appropriate use of biotech/specialty medications and monitors patient safety.

Caremark.com is an easy way to make the most of your prescription benefits:

- Find network pharmacies
- Refill medication and check order status
- Check drug costs
- See your prescription history

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Welcome to Meritain Health® Pharmacy Solutions (MPS)

MPS is nationwide pharmacy benefit manager (PBM). Our job is simple: we help take care of you. Your employer has partnered with us for your prescription benefits.

It's important for you to understand how your prescription benefits work—we get that. That's why we're here to give you the information, tools and services you need to make the most of your benefits program.

Find participating pharmacies

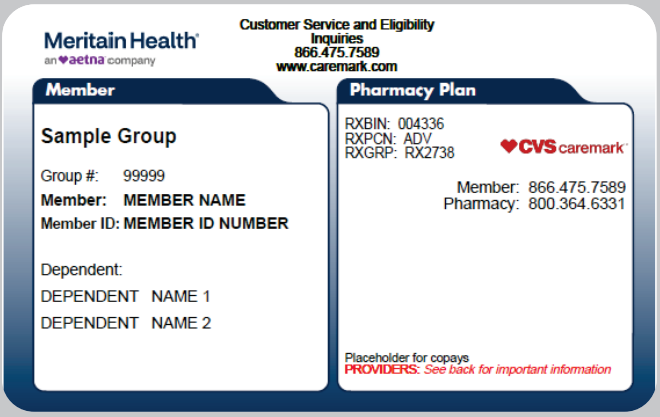
You can find a participating pharmacy by visiting **www.Caremark.com**. Log in to or create your member account and search for nearby pharmacies, convenient to you.

We're here when you need us

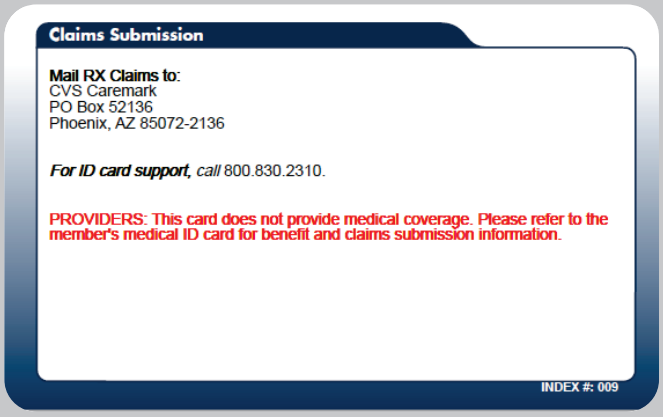
Still have questions? We can help. Just give us a call at the number on your ID card.

Sample ID card

Card front



Card back



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Participating National Network Retail Pharmacies

The network includes all major chains and most independent pharmacies. The following list shows the major chain pharmacies that accept your prescription ID card. In addition to the pharmacies listed below, many independent pharmacies also take part in the prescription program. To find out if a pharmacy not listed here accepts your card, call the pharmacy directly.

A

A & P Pharmacy
Accredo Health Group, Inc.
ACME Pharmacy
Albertson's Pharmacy
Aurora Pharmacy

B

Baker's Pharmacy
Bartell Drugs
Bel Air Pharmacy
Brookshire Brothers Pharmacy

C

CarePlus
Caremark Specialty Pharmacy
Carrs-Gottstein Foods Pharmacy
Cashwise Pharmacy
CenterWell Pharmacy
City Market Pharmacy
Coborn's Pharmacy
Copps Food Center Pharmacy
Coram CVS Specialty Pharmacy
Costco Pharmacy

C

Cub Pharmacy
CVS Pharmacy
CVS Pharmacy in Target stores
CVS Specialty

D

Dillon Pharmacy
Discount Drug Mart
Doc's Pharmacy
Duane Reade

E

Eaton Apothecary
Essentia Health

F

Fairview Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fresh Market Pharmacy
Fruth Pharmacy
Fry's Food and Drug

G

Gerbes Pharmacy
Giant Eagle Pharmacy
Giant Pharmacy
Group Health Pharmacy

H

Haggen Pharmacy
Hannaford Food & Drug
Harmons Pharmacy
Harps Pharmacy
Harris Teeter Pharmacy
Healthsmart Pharmacy
H-E-B Pharmacy
Hen House Pharmacy
Henry Ford Medical Center Pharmacy
Homeland Pharmacy
Hy-Vee Pharmacy

I

IHC Health Center
Ingles Pharmacy

Caremark.com

CVS Caremark® reserves the right to review and update the Participating National Network Retail Pharmacies List.

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National Network Participating Retail Pharmacies (cont.)

J

Jewel-Osco Pharmacy

K

Kessel Pharmacy
King Soopers Pharmacy
Kinney Drugs
Klein's Pharmacy
Klingensmith's Drug Stores
Knight Drugs
Kroger Pharmacy
Kroger Sav-On Pharmacy

L

Longs Drug Store

M

Marianos Pharmacy
Martin's Pharmacy
Maxor Pharmacies
Med-Fast Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy
Meijer Pharmacy
Mercy Pharmacy
Metro Market Pharmacy

N

Navarro Discount Pharmacy
NCS Healthcare Pharmacy
Neighborcare Pharmacy
Nob Hill Pharmacy
North Florida Pharmacy

O

Omnicare Pharmacy
Oncology Pharmacy
Option Care Pharmacy
Osco Pharmacy

P

Pavilions Pharmacy
Pharmerica
Pick N Save Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy

Q

QFC Pharmacy

R

Raley's Drug Center
Ralphs Pharmacy
Randall's Pharmacy
Rite Aid Pharmacy

S

Safeway Pharmacy
Sam's Club Pharmacy
Sav-Mor Pharmacy
Save Mart Pharmacy
Sav-On Pharmacy
Schnucks Pharmacy
Scott's Pharmacy
Shaw's Pharmacy
Shop 'n Save Pharmacy
Shoppers Pharmacy
ShopRite Pharmacy
Smith's Pharmacy
St. John Pharmacy
Stop & Shop Pharmacy
Super 1 Pharmacy

T

Texas Oncology Pharmacy
Thrifty White Pharmacy
Times Pharmacy
Tom Thumb Pharmacy
Tops Pharmacy

U

United Market Street Pharmacy
United Pharmacy
USA Drug
UW Health Pharmacy Services

V

Vons Pharmacy

W

Walgreens Pharmacy
Walmart
Wegman's Pharmacy
Weis Pharmacy
White Drug

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Health Reimbursement Account (HRA)

Plan Explanation

Ursinus College will continue to provide the Health Reimbursement Account and use the Harrison Group as our "Health Reimbursement Account" (HRA) Administrator. Because the upcoming plan year is a short plan year (11/1/2024-6/30/2025), Ursinus College is increasing the HRA funding for this year only. HRA funding is expected to return to regular funding amounts for future 12-month plan years.

HRA	
What is a Health Reimbursement Account (HRA)?	An HRA is an employer-funded plan that pays for eligible expenses in coordination with our medical health plan.
Name of Health Plan used with the HRA	Bronze and Silver Plans
Who is eligible?	Employees that are enrolled into the Silver or Bronze Medical Plans are eligible for the HRA.
Who funds the HRA?	Your employer funds the HRA.
How does the plan work?	The HRA will reimburse expenses applied towards your In-Network Deductible under either the Bronze or Silver Plan. You will be responsible for the FIRST portion of your deductible and then the HRA will reimburse you for the SECOND portion.
HRA Short Plan Year	Because the upcoming plan year is a short plan year (11/1/2024-6/30/2025), Ursinus College is increasing the HRA funding for this upcoming plan year only.
HRA DETAILS BY MEDICAL PLAN	
BRONZE Plan HRA Funding Amount	$2,500 Single (Employee Only) $5,000 Family (Employee/Spouse, Employee/Child(ren), Employee/Family)
BRONZE Plan HRA In-Network Deductible	$4,000 Single (Employee Only) $8,000 Family (Employee/Spouse, Employee/Child(ren), Employee/Family)
BRONZE Plan Reimbursement Details	You will be responsible for the FIRST $1,500 for single coverage or $3,000 for family coverage. Your HRA will reimburse the SECOND $2,500 for single coverage or $5,000 for family coverage.
SILVER Plan HRA Funding Amount	$1,500 Single (Employee Only) $3,000 Family (Employee/Spouse, Employee/Child(ren), Employee/Family)
SILVER Plan HRA In-Network Deductible	$2,500 Single (Employee Only) $5,000 Family (Employee/Spouse, Employee/Child(ren), Employee/Family)
SILVER Plan Reimbursement Details	You will be responsible for the FIRST $1,000 for single coverage or $2,000 for family coverage. Your HRA will reimburse the SECOND $1,500 for single coverage or $3,000 for family coverage.
PLAN INFORMATION	
Short Plan Year	November 1, 2024 - June 30, 2025
How to file an HRA claim	To activate the HRA, you must send the Activation Form and a copy of your Meritain Explanation of Benefits (EOB) showing that you have reached the first portion of your deductible. You will receive a smart card that works for both the HRA and HSA. You can also file claims online by visiting The Harrison Group portal.
Member Website	www.theharrisongrouponline.com
The Harrison Group Service Contact	Phone: 610-853-9075 Email: service@theharrisongrouponline.com

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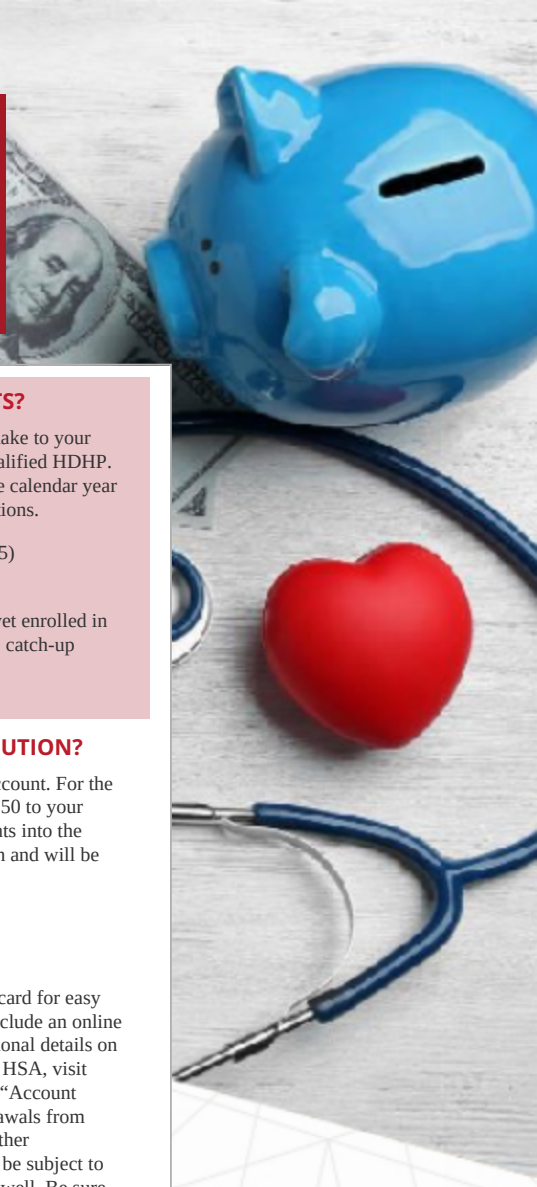
Health Savings Account



WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

A Health Savings Account (HSA) is a savings account that allows individuals to pay for current qualified medical expenses and save toward future medical expenses on a tax-free basis. To qualify for an HSA, you must first be enrolled in a Qualified High-Deductible Health Plan (HDHP).

Both the **Bronze** and **Silver** Meritain Medical Plans are considered Qualified HDHPs.

ARE THERE ANY CONTRIBUTION LIMITS?

Yes. The maximum annual contribution you can make to your HSA is based on how you are enrolled into the Qualified HDHP. IRS Maximum Contribution limits are based on the calendar year and include both employee and employer contributions.

- **Individual**: $4,150 (2024); $4,300 (2025)
- **Family**: $8,300 (2024); $8,550 (2025)

Account holders over the age of 55 who have not yet enrolled in Medicare are eligible to make an additional $1,000 catch-up contribution.

WHAT ARE HSA ELIGIBLE EXPENSES?

Eligible Expenses under the HSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital Bills, Dental Expenses, Vision Expenses, etc. Please note: There are penalties if you use the HSA for non-qualified expenses.

IS THERE AN EMPLOYER HSA CONTRIBUTION?

Yes, Ursinus College helps you build your HSA account. For the upcoming plan year, the College will contribute $350 to your HSA account at the end of January. For new entrants into the plan, this amount is equivalent to $29.17 per month and will be pro-rated based on the date of eligibility.

WHO IS ELIGIBLE FOR AN HSA?

Employees that are enrolled into either the **Bronze** or **Silver** medical plan options are eligible for the HSA. An HSA-eligible individual is one whom is covered under an HSA-qualified high deductible health plan (HDHP), cannot be claimed as a tax dependent by another individual on his or her income tax return, is not entitled to Medicare (i.e., eligible and enrolled), and does not have other disqualifying coverage. Examples of disqualifying coverage include a general purpose FSA, HRA, or coverage on a spouse's non-HDHP. An individual with a spouse enrolled in a general purpose FSA, in which both spouses have access to the funds, regardless of how the funds are actually spent, is considered HSA disqualifying coverage for both spouses. Only an eligible individual may make HSA contributions as well as have them made on his or her behalf.

HOW CAN I ACCESS THE FUNDS?

When your account is opened, you receive a debit card for easy access to your funds. Other withdrawal methods include an online bill payment and funds transfer services. For additional details on exactly how you may access the funds within your HSA, visit www.theharrisongrouponline.com and navigate to "Account Features > Banking Services." If you make withdrawals from your HSA for non-qualified medical expenses or other nonqualified expenses, the amount withdrawn will be subject to income tax and may be subject to an excise tax, as well. Be sure to track all of your withdrawals from your HSA so you can supply documentation of your expenditures, if required by the IRS. It is up to you to monitor the deposits and withdrawals made to and from your HSA.

WHEN CAN I ENROLL IN AN HSA?

Typically, you'll enroll in an HSA during your open enrollment period when you make your annual benefit elections. Contributions to an HSA can only be made if you are an HSA-eligible individual enrolled into either the Bronze or Silver medical plans.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

No - all unused funds remain in your account - just like a regular savings account. Your contributions will remain in your account until you are ready to use them – there is no annual requirement to "use or lose" your funds.

WHAT TAX BENEFITS ARE THERE?

Health Savings Accounts provide a triple tax advantage: money contributed is tax-free, earnings are tax-free, and withdrawals for qualified medical expenses are tax-free.

HOW DO I CONTRIBUTE & WHEN ARE FUNDS AVAILABLE?

Your employer allows you to contribute through pre-tax payroll deductions. The account is funded on a per pay basis.

CAN I CONTRIBUTE AFTER I TURN 65?

Generally, no. You cannot contribute after you turn 65, but you can use any funds you have left in your account.

HOW DO I USE IT?

The Harrison Group will provide you with a debit card that you can use to pay for eligible expenses.

IS THE HSA PORTABLE?

Yes. The HSA is your personal savings account. The money in this account is yours no matter where you are employed.

MEMBER WEBSITE

www.theharrisongrouponline.com

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Flexible Spending Accounts

WHAT IS A FLEXIBLE SAVINGS ACCOUNT (FSA)?

A Flexible Spending Account (FSA) allows you to have money deducted from your pay on a pre-tax basis and deposited in an account that you can use to pay for eligible expenses. There are two types of accounts: Healthcare FSA and a Dependent Day Care FSA.

This will be a short-plan year that will run from November 1, 2024 through June 30, 2025. The Harrison Group will continue to administer the Flexible Spending Accounts.

ARE THERE ANY CONTRIBUTION LIMITS?

Yes, for this short plan year from 11/1/2024-6/30/2025, the maximum contribution limit for each FSA account are as follows:

- **Healthcare FSA**: $2,133.33
- **Dependent Day Care FSA**: $3,333.33
  - If married and filing separately, the maximum is $1,666.67

WHAT ARE FSA ELIGIBLE EXPENSES?

Healthcare FSA Eligible Expenses: You can use your healthcare FSA dollars on Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are deductibles, copays, prescriptions, hospital bills, dental charges, vision expenses, and eligible over the counter items.

Dependent Day Care Eligible Expenses: If you and your spouse (if married) are working or in school full-time, you can use your DCA account to pay for eligible expenses for your dependent children under the age of 13 or elder dependents that you claim as a dependent on your federal tax return who is mentally or physically incapable of self-care. Examples of elible expenses include: after-school care or extended day programs, nursery or pre-school, elder care center, and day camps.

DO USE-IT-OR-LOSE-IT RULES APPLY FOR THE FLEXIBLE SPENDING ACCOUNTS?

Yes. Whether you participate in a Healthcare FSA or Dependent Day Care Account, you will need to set your contribution amount carefully. Estimate your anticipated out of pocket expenses to put aside enough to cover them, without contributing more than you need.

If you contribute dollars to either the Healthcare FSA or Dependent Day Care Account and do not use all funds deposited within the plan year, you will have an additional *2.5 month spending grace period* to spend down your balances after the close of the plan year. Any remaining balance in the account after that time will be forfeited. This is what is known as the "use-it-or-lose-it" provision that is applicable to both FSA accounts.

WHEN CAN I ACCESS THE FUNDS?

Access to funds differ between the Medical FSA and the Dependent Day Care.

- The Medical FSA allows immediate access to the entire election on day 1 of the benefit year; you will be payroll deducted throughout the year.
- The Dependent Day Care Account is funded on a per-pay basis; the amount available for reimbursement is limited to the amount that has been contributed to the account to date.

WHO IS ELIGIBLE FOR AN FSA?

Eligibility for the accounts are based on the type of Flexible Spending Account.

- You are eligible for the Healthcare FSA if you are enrolled into the Gold Medical Plan or if you have opted out of medical coverage.
- You are eligible for the Dependent Day Care Account if you are benefit-eligible and have an eligible dependent.

WHAT TAX BENEFITS ARE THERE?

Flexible Spending Accounts enable you to set aside a pre-determined dollar amount in an account to cover eligible expenses. IRS rules allow you to contribute to your accounts through payroll deduction on a pre-tax basis, reducing your taxable income.

WHEN CAN I ENROLL FOR AN FSA?

Since the contributions are made via pre-tax payroll deductions, you may only enroll at open enrollment or when you have a mid year qualifying event.

HOW DO I USE IT?

The Harrison Group will provide you with a debit card that you can swipe or you can submit claim forms along with itemized bills from your provider to obtain reimbursement.

HOW DO I CONTRIBUTE?

You contribute to both the Healthcare FSA and Dependent Day Care Account through pre-tax payroll deductions throughout the plan year.

IS THE FSA PORTABLE?

No - this is an employer owned account and it is not portable.

The Harrison Group Contact Information

Website: www.theharrisongrouponline.com

Phone: 610-853-9075

Email: service@theharrisongrouponline.com

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Dental Plans

Plan Explanation

The dental coverage will change to MetLife for the upcoming plan year. There are enhanced benefits available on both the Low and High Plan options. You can verify if your current dentist is in-network with the new dental plan by visiting www.metlife.com and searching under the PDP Plus plan network. Instructions are included on the following page. Once enrolled, you can also register online at www.metlife.com/mybenefits.

	MetLife | Low Plan		**MetLife** | High Plan	
DEDUCTIBLE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Single	$0	$0	$0	$0
Family	$0	$0	$0	$0
MAXIMUM THE CARRIER WILL PAY				
Annual Maximum (Calendar Year)	$1,000	$1,000	$2,000	$2,000
FREQUENCIES				
Cleaning	2 Per Year		2 Per Year	
Exam	2 Per Year		2 Per Year	
DENTAL COVERAGE				
Cleanings	100%	100%	100%	100%
Exams	100%	100%	100%	100%
Basic Services	100%	100%	100%	100%
Major Services	50%	50%	50%	50%
Endo	100%	100%	100%	100%
Perio, Oral Surgery	50%	50%	100%	100%
Orthodontia	Not Covered	Not Covered	50%	50%
Orthodontia Lifetime Maximum	Not Covered		$2,500	
Orthodontia Maximum Age	Not Covered		Orthodontia benefit is available to both children and adults	
OUT OF NETWORK EXPLANATION				
	The out of network benefits are based on the Maximum Allowable Charge (MAC). The insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.		Out of network benefits are based on the Usual, Customary, and Reasonable (UCR) charge, which is based on what 80% of dentists in a geographical area bill for the service. You can be balance billed for the difference when visiting an out of network provider.	
PLAN INFORMATION				
Network Type	www.metlife.com		www.metlife.com	
Network Name	PDP Plus		PDP Plus	

PREMIUM PER MONTH		
Employee Only	$13.00	$32.31
Employee + Child(ren)	$61.38	$117.90
Employee + Spouse	$61.38	$117.90
Family	$61.38	$117.90

MetLife®

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

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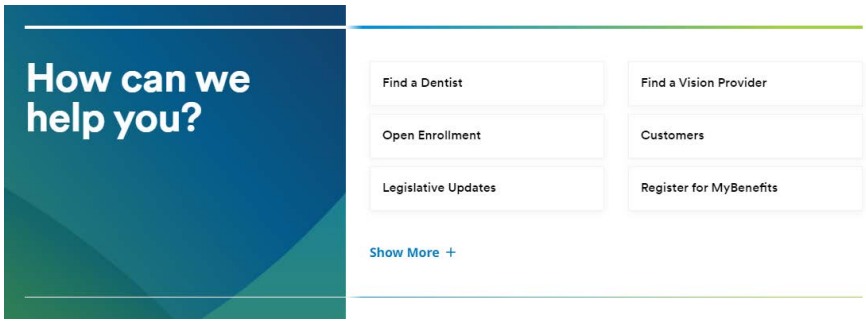
MetLife | Dental Insurance

Find a Dental Provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

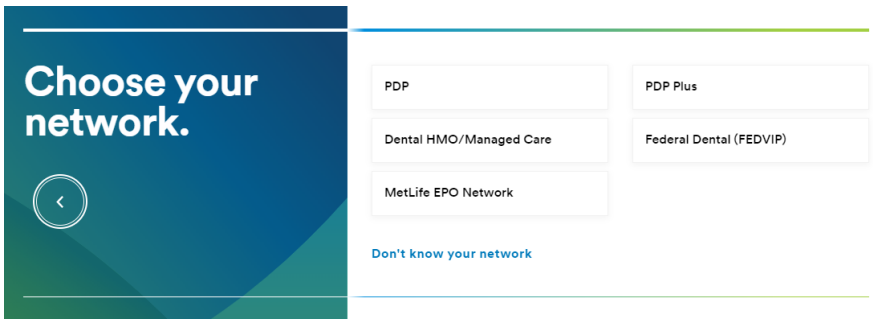
Step 1:
Go to metlife.com

Step 2:
Select "Find a Dentist" next to "How can we help you?"



Step 3:
Select "PDP Plus" next to "Choose your network."

Enter your Zip, City or State and select the "Find a Dentist" button.



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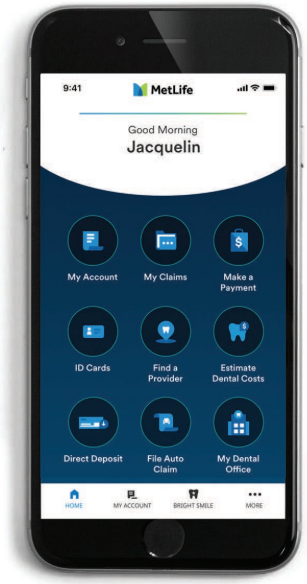
MetLife | Dental Insurance

Viewing your dental plan just got easier

MetLife's mobile app puts convenience in the palm of your hands. You can quickly access and manage your dental benefit information — anytime, anywhere.

You can:

- Find a dentist
- Get estimates for most procedures to display personalized, plan specific costs and information such as percent covered, applicable deductible, Plan Maximum and Frequency Limits
  - Both in-network and out-of-network estimates available PPO Plan Only
- View your plan summary with quick links to important information on deductibles and Plan Maximums as well as Covered Services
- View detailed coverage information such as benefit sharing percentage and Frequency Limits
- View your claims
- Track your brushing and flossing
- Access and save ID card to photo library or mobile app



It's easy to get the MetLife US Mobile app!

Search "MetLife" in the App Store® or Google Play® and download the MetLife US Mobile App, or scan these QR codes. Search out network of thousands of dentists and specialists to find a provider near you.

Or log-in to MyBenefits to access your plan information.[1]

GET IT ON Google play

Download on the App Store

It's available 24 hours a day, seven days a week.

[1] To use the MetLife mobile app, employees can choose to register at metlife.com/mybenefits from a computer or directly through the app. Certain features of MetLife US Mobile App are not available for some MetLife Dental Plans.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

ADF# D3064.23

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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Vision Plans

Plan Explanation

The vision coverage will remain with VBA for the upcoming plan year. The Base Vision Plan is tied to medical enrollment so if you enroll into a Meritain medical plan, you will automatically be enrolled into the Base Vision Plan. If you waive medical coverage or if you wish to elect the new Buy-Up Vision Plan in place of the Base Plan, you have the option to do so.

	VBA | Base - Tied to Medical Plan Enrollment		**VBA** | Buy-Up - Voluntary	
VISION COVERAGE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Eye Exam	$25	$45 Reimbursement	$25	$45 Reimbursement
Single Vision Lens	$25	$40 Reimbursement	$25	$40 Reimbursement
Bi-Focal Lens	$25	$60 Reimbursement	$25	$60 Reimbursement
Tri-Focal Lens	$25	$80 Reimbursement	$25	$80 Reimbursement
Contact Lens Allowance	$100	$100 Reimbursement	$130	$130 Reimbursement
Frame Allowance	$100	$70 Reimbursement	$130	$70 Reimbursement
FREQUENCIES				
Exam Frequency	24 Months		12 Months	
Contact Lenses Frequency	24 Months		12 Months	
Frame Frequency	24 Months		24 Months	
OUT OF NETWORK EXPLANATION				
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you.		While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you.	
PLAN INFORMATION				
Limitations	Benefits may only be used for contact lenses when selected in lieu of eyeglasses (spectacle lenses and frames). You may use either the spectacle lenses OR contact lenses benefit within a benefit period.		Benefits may only be used for contact lenses when selected in lieu of eyeglasses (spectacle lenses and frames). You may use either the spectacle lenses OR contact lenses benefit within a benefit period.	
Network Name	VBA		VBA	
Member Website	www.vbaplans.com/vision		www.vbaplans.com/vision	
Customer Service Phone Number	1-800-432-4966		1-800-432-4966	

PREMIUM PER MONTH		
Employee Only	N/A; Included with medical enrollment	$4.82
Employee + Child(ren)	N/A; Included with medical enrollment	$9.41
Employee + Spouse	N/A; Included with medical enrollment	$9.17
Family	N/A; Included with medical enrollment	$12.55

Disclaimer

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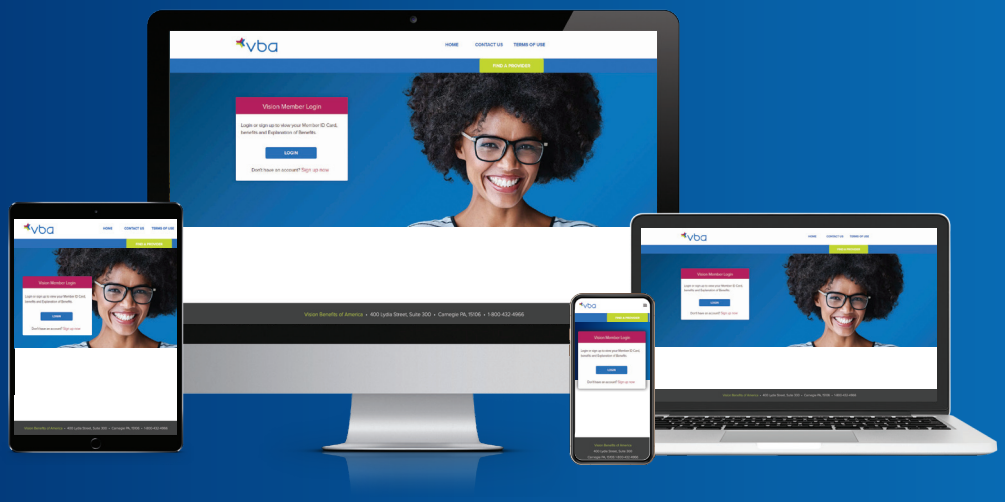
USING THE

VBA Member Portal



VBA's Easy-to-Use Member Portal

At VBA, we strive to make things as simple as possible for our members. Our focus is always on you, which you'll see in every aspect of our mobile-friendly member portal. You can:

- Find in-network providers
- Chat online with customer service representatives
- Print ID cards
- Download Explanation of Benefits statements
- Submit out-of-network claims

Access the VBA Member Portal

To create a more secure user experience, all VBA members are required to register their account before accessing the VBA Member Portal.

Register Your Account

1. Go to vbaplans.com and click Login from the menu.
2. Select Vision and Member options and click Sign In.
3. Select Sign Up Now.
4. Enter your email address, the policyholder's birth date, zip code and last four digits of SSN or Member ID and click Send Verification Code.
5. You will receive an email with a One-Time Code from noreply@visionbenefits.com.
6. Enter your One-Time Code and click Verify Code.
7. Select Next, and access your benefits information.

Login to Your Account

1. Go to vbaplans.com and click Login from the menu.
2. Select Vision and Member options and click Sign In.
3. Select Login.
4. Enter the email address you used to register your account and click Send Verification Code.
5. You will receive an email with a One-Time Code from noreply@visionbenefits.com.
6. Enter your One-Time Code and click Verify Code.
7. Select Next, and access your benefits information.

Each policyholder may only register their account with one email address. If your covered dependents need to access the VBA Member Portal, they must enter the registered email address and One-Time Code sent to the same email address to login.

Did You Know?

A member card is not necessary to access your benefits. You can print your VBA member card so that you have all of your plan information handy whenever you visit your doctor's office.

You can use our online Provider Finder to search for doctors in the VBA Network.

Always confirm eligibility through the Member Portal before receiving services or purchasing materials.

We're here to answer your questions.

Our customer care representatives are available by phone Monday through Friday 8:30 AM - 6:00 PM ET by calling 1-800-432-4966.

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Life Insurance

Plan Explanation

The Employer Paid Life Insurance and Voluntary Life coverages are moving to Mutual of Omaha effective November 1, 2024. If you currently have Voluntary Life Insurance coverage in place today, Mutual of Omaha will grandfather your existing voluntary life coverage amounts if you do not wish to make any changes. If you would like to newly enroll or increase your coverage during this open enrollment period only, you can elect up the Guaranteed Issue Amounts without having to complete Evidence of Insurability (EOI). If you wish to newly enroll or increase your current coverage above the Guaranteed Issue Amounts, EOI will be required.

Mutual of Omaha | Employer Paid Life/AD&D Insurance

LIFE INSURANCE BENEFITS	
Life/AD&D Insurance Coverage	1x Salary to a Maximum of $250,000
Age Reduction Schedule	Benefit reduces to 65% at age 65 and 50% at age 70
Beneficiary	A beneficiary designation is required for your life insurance policy.

Mutual of Omaha | Voluntary Life/AD&D

LIFE INSURANCE BENEFITS	
Employee Coverage	5x Salary up to $500,000 Maximum; Coverage can be purchased in $10,000 increments
Spouse Coverage (Only available if the employee has employee voluntary life in place)	100% of Employee Amount up to $500,000; Coverage can be purchased in $5,000 increments. Spouse coverage terminates at age 75.
Child(ren) Coverage (Only available if the employee has employee voluntary life in place)	Live Birth to 6 Months: $1,000 6 Months to Age 26: $2,000 up to $10,000 maximum Coverage can be purchased in $2,000 increments
Age-Banded Rates	The voluntary life coverage has age-banded rates. The premium for this coverage will depend on the employee's age and volume of coverage requested.
Age Reduction Schedule	Benefit reduces to 65% at age 70 and 50% at age 75
Guaranteed Insurability	Employee: $150,000 Spouse: $25,000 Children: Full Benefit
Beneficiary	A beneficiary designation is required for your life insurance policy.
Grandfather Existing Life Insurance	If you currently have voluntary life coverage in place, you will be grandfathered to Mutual of Omaha at your current level of coverage without having to complete Evidence of Insurability.
EVIDENCE OF INSURABILITY RULES	
Plan Year	During this initial open enrollment period effective 11/1/2024, you can elect coverage up to the guaranteed issue amounts without having to complete an Evidence of Insurability (EOI) form. If you wish to elect coverage above the guaranteed issue, an EOI must be completed and submitted to Mutual of Omaha. After review, Mutual can approve or deny your request for coverage.
EOI Online Submissions	www.mutualofomaha.com/eoi
EOI Policy Number to Include for Online Submission	New1

Mutual of Omaha

Disclaimer

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Disability

Plan Explanation

Short Term Disability and Long Term Disability are income-protection beenfits that provide continuation of your salary if you cannot work due to a qualified injury or illness.

| Short Term Disability

STD INSURANCE BENEFITS	
Summary	Short Term Disability provides continuation of your salary on a short-term basis if you cannot work due to a qualified injury or illness.
Policy	This policy provides full pay during the first 8 weeks of the approved leave, then 1 week of full pay for each year of full-time service, followed by 60% of full pay for the remaining weeks.
Purpose	This leave is to assist employees through the 90-day waiting period required under Long Term Disability.

| Long Term Disability

LTD INSURANCE BENEFITS	
Summary	If you are disabled due to a non-work related illness or injury, you could be eligible for Long Term Disability coverage.
Monthly Benefit	60% of pre-disability earnings to a monthly maximum benefit of $10,000
When do benefits start? (Elimination period)	Benefits begin after 90 days of a covered illness or injury
Duration of Benefit	Benefits can continue up to Social Security Normal Retirement Age, subject to Physician and Carrier approval.
Own Occupation Period	2 Years

Disclaimer

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EMPLOYEE ASSISTANCE PROGRAM

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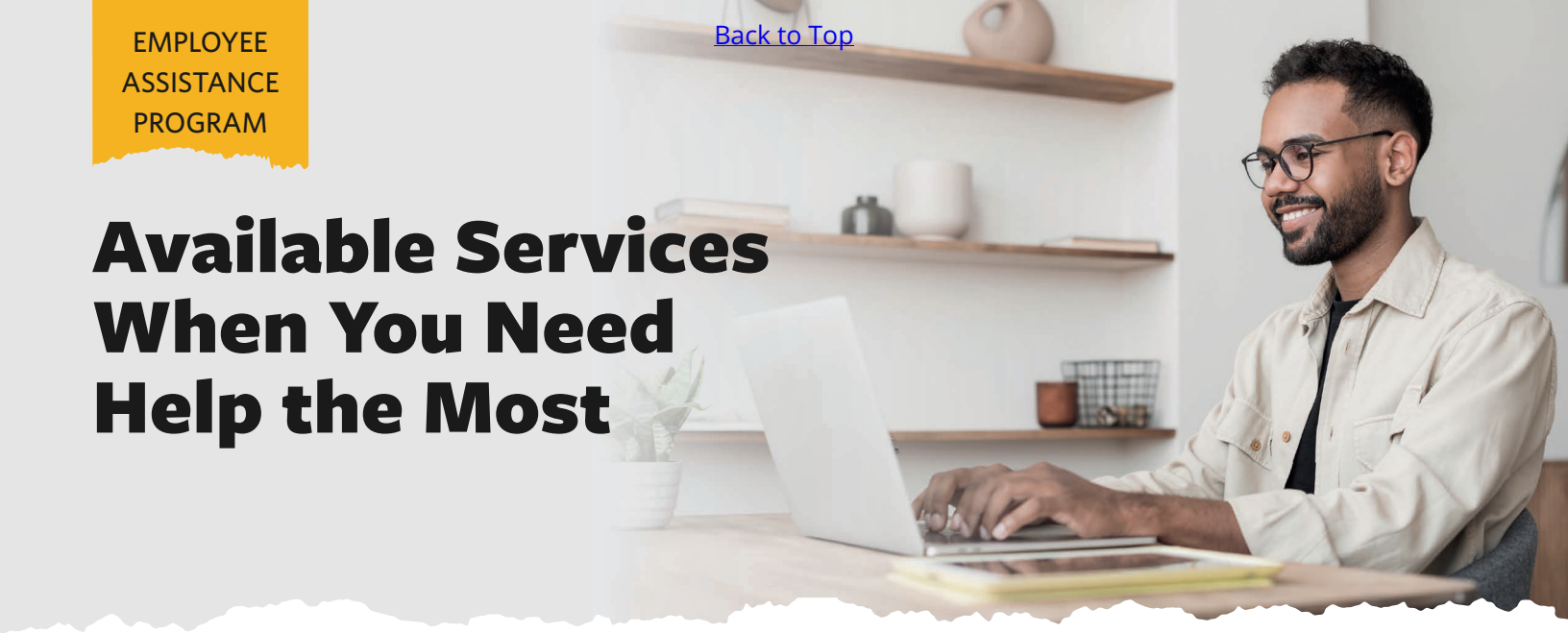

Available Services When You Need Help the Most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

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Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers for face-to-face counseling • National network of more than 30,000 licensed clinical providers for telehealth counseling • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources — legal libraries, tools and forms — available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  ◦ Current events and resources
	  ◦ Family and relationships
	  ◦ Emotional well-being
	  ◦ Financial wellness
	  ◦ Substance abuse and addiction
	  ◦ Legal assistance
	  ◦ Physical well-being
	  ◦ Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

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Retirement Plan

TIAA | 403B

403B RETIREMENT PLAN:

Defined Contribution Plan

This program is mandatory for all full-time employees, age 18 or older, who have satisfied the new hire waiting period. Full-time employees are those employed on a regular basis who are hired to work a full daily schedule each week (35 hours or more). You are eligible for this plan once you have satisfied the initial 6-month waiting period after your date of hire. Once the waiting period has been satisfied, the eligible employee contributes a minimum of 4% of his/her base salary and the College contributes 4% of the same salary base.

Tax-Deferred Annuity Plan

All employees of the college (full-time and part-time) may participate in a tax deferral arrangement authorized in Section 403(b). Available through our tax-deferred annuity plan, Voluntary Retirement Contracts provide the opportunity for all employees to make contributions to a retirement plan on a pre-tax basis through TIAA-CREF. There is neither a minimum age requirement nor any waiting period to join. The College makes no contribution to this plan. Contributions made to the Retirement Contract Plus Plans are not a substitute for participation in the regular defined contribution retirement plan when one qualifies for that Plan.

Contributions for the 2024 calendar year:

The voluntary individual maximum permitted by law is $23,000. Catch-Up Contributions: For employees who have attained age 50 or over anytime during the calendar year of this agreement, may elect to contribute up to an additional $7,500.

TIAA Contact Information for 403B:

- TIAA Support
- Call 800-842-2252 to talk about retirement
- Available every weekday from 8AM to 10PM (EST)

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Retiree Health

Emeriti | Emeriti Program

Emeriti Program

The College participates in Emeriti Health Solution, a consortium of colleges and universities organized to address retiree health care needs.

What is the Emeriti Program?

The Emeriti program was developed for the purpose of accumulating funds during the working years to be used for health insurance or health care expenses after retirement. The funds are deposited into a Voluntary Employee Benefits Association (VEBA) account which is serviced by TIAA-CREF through December 31, 2024 and then servicing will be transferred to OneBridge.

How Does the Plan Work?

Effective, November 1, 2024, the College is no longer contributing to the Emeriti Program.

Employees over the age of 40 or older may participate in the plan. Contributions will be made on an after-tax basis. While the contribution is taxable, the appreciation in the value of the investments would not be taxed when the funds are withdrawn.

Employees must be at least 60 years of age and have at least five years of service as a full-time employee to satisfy the requirements for retirement from the College. Retirement will mean that the employee will be eligible to participate in the Emeriti Health insurance program currently offered through Aetna.

Employees who wish to leave the employment of the College will own their retirement savings in their TIAA-CREF accounts and their health care savings in their VEBA accounts.

Plan Highlights

Important Notices for Employees:

April 2013-Summary of Material Modifications

HIPAA Privacy Notice

Related Forms:

Banking Information and Electronic Transfer Form

Reimbursement Claim Form

Rx Debit Card Form

Contact Information:

For more information about the Emeriti Retirement Health Solutions Program:

call 1-866-EMERITI OR visit the website at **www.emeritihealth.org**

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Insurance Terms and Definitions

DEDUCTIBLE
The amount you pay before the insurance carrier starts sharing the expense of your medical care.

EMBEDDED DEDUCTIBLE
This only applies to employees who have dependents enrolled on their plans. In an Embedded deductible, no member of the family unit can satisfy more than the single deductible during the deductible period. Even though the family is subject to the family deductible as a whole, no one person can satisfy more than the single deductible.

AGGREGATE DEDUCTIBLE
This only applies to employees who have dependent enrolled on their plans. In an Aggregate deductible, one member of the family can satisfy the entire family deductible during the deductible period.

OUT OF NETWORK BENEFITS
The medical plans have separate out of network deductibles that would first need to be satisfied before the plan reimburses. For out-of-network services, the doctor may not accept your plan's fee as payment in full and may charge you the difference between what your carrier pays once your deductible is satisfied and what the doctor's office charges. Your physician may also require you to pay out of pocket.

CO-INSURANCE
After you've reached your deductible for the year, the insurance carrier will split the balance of the medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum

OUT OF POCKET MAXIMUM
This is the maximum amount you will pay for covered medical expenses during the year.

CO-PAYS
This is a set Dollar amount you pay when you receive medical care for certain services. It's called a co-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility.

NEGOTIATED RATE (CONTRACTED RATE)
When a Provider (doctor, facility, pharmacy or hospital) contracts with an insurance carrier, they are considered In-Network. Part of the contract states that the provider will accept a lower payment (lower than what they normally charge) from the insurance carrier as payment in full. This lower payment is the Negotiated Rate.

EXPLANATION OF BENEFITS
Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

HEALTH REIMBURSEMENT ACCOUNT (HRA)
This is an account funded by your employer, where you are reimbursed for the second portion of your deductible. The goal is to help lower your overall out of pocket expense for the year.

HEALTH SAVINGS ACCOUNT (HSA)
This is an Employee Owned savings account that allows you to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. In order to be eligible to make HSA contributions, you must be an eligible individual that is enrolled into a Qualfied High Deductible Health Plan (HDHP). This is a true savings account plan, so you can rollover all unused funds from year to year. With an HSA, money has to be in the account for you to be able to use it.

FLEXIBLE SPENDING ACCOUNT (FSA)
There are two types of Flexible Spending Accounts: Healthcare FSA and Dependent Day Care. You can contribute funds on a pre-tax basis to pay for qualified expenses during the course of the plan year. There are "use-it-or-lose-it" rules in place for these accounts.

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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). However, you must request enrollment within 31 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources Team.

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

WHCRA Annual Notice

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

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Premium Assistance Under Medicaid and the

Children's Health Insurance Program (CHIP)

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**

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Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
https://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 1/31/2026)