



Keystone College Open Enrollment Guide

All Full-Time Eligible Employees
Effective: June 1, 2025



EXPLORE YOUR BENEFITS

Keystone College strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you are getting the most out of your benefits – that is why we put together this Open Enrollment Guide.

BENEFIT PLAN YEAR June 1, 2025 – May 31, 2026

WHO IS ELIGIBLE?

If you're a full-time employee at Keystone College, you're eligible to enroll in the benefits outlined in this guide. In addition, the following family members are eligible for medical, dental and vision coverage:

- Spouses or Domestic Partners and Children under 26

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did anything change within the last year? Verify all of your personal information and make any necessary changes. Once all your information is up to date, it's time to make your benefit elections. **This year you will login to Flock to make your 2025 benefit elections.**

WHEN TO ENROLL

Open enrollment begins on April 29th through May 16th. The benefits you choose during open enrollment will become effective on June 1st.

HOW TO MAKE CHANGES

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

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



BENEFIT QUESTIONS?

Contact the Customer Support Team at OneSource.
customersupport@onesource-benefits.com

We can help with:

- Benefits
- Claims that are denied
 - Provider bills
- Ordering new ID cards
- Enrolling in benefits for the first time
- Changes to or finding providers in your network

Contact Us at OneSource Benefit Solutions!

GROUP CONTACTS

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HEALTH INSURANCE Option 1 \$5,000 HMO

You will continue to have the option to choose between a \$5,000 deductible and a \$2,000 deductible option with both HMO and PPO Networks. The four plan designs are summarized on the following pages and the network differences are summarized on page 8.

Geisinger All-Access Extra HMO	
Preferred Provider	
Deductible	\$5,000
Coinsurance	20%
Coinsurance Maximum	\$2,500
Telemedicine Visit	\$5 PCP / \$10 Specialist
PCP Office Visits	\$10 Extra Site OR \$25
Specialist Office Visits	\$50
Preventive Services	100% Covered – No Charge
Physical, Occupational, Speech Therapy	\$50
Chiropractic Services (15 Visits)	\$25
X-rays, laboratory, and other diagnostic tests	20% After Deductible
High-tech Imaging (MRI, MRA, CT scan, PET scans)	20% After Deductible
Emergency Care	\$200 Copay (Waived if Admitted)
Urgent Care	\$25
Hospitalization (Inpatient)	20% After Deductible
Prescriptions	
Low Cost Generic/Generic	\$0 or \$25
Formulary Brand	\$50
Non-Formulary Brand	\$75
Non-Preferred Provider	No Out Of Network Coverage

HEALTH INSURANCE Option 2 \$5,000 PPO

Geisinger All-Access PPO	
Preferred Provider	
Deductible	\$5,000
Coinsurance	20%
Coinsurance Maximum	\$2,500
Telemedicine Visit	\$5 PCP / \$10 Specialist
PCP Office Visits	\$25
Specialist Office Visits	\$50
Preventive Services	100% Covered – No Charge
Physical, Occupational, Speech Therapy	\$50
Chiropractic Services (15 Visits)	\$25
X-rays, laboratory, and other diagnostic tests	20% After Deductible
High-tech Imaging (MRI, MRA, CT scan, PET scans)	20% After Deductible
Emergency Care	\$200 Copay (Waived if Admitted)
Urgent Care	\$25
Hospitalization (Inpatient)	20% After Deductible
Prescriptions	
Low Cost Generic/Generic	\$0 or \$25
Formulary Brand	\$50
Non-Formulary Brand	\$75
Non-Preferred Provider	\$10,000 Deductible + 30% Coinsurance Coinsurance Maximum: \$15,000



HEALTH INSURANCE Option 3 \$2,000 HMO

Geisinger All-Access Extra HMO

Preferred Provider	
Deductible (Single / Family)	\$2,000 / \$4,000
Coinsurance	None
Coinsurance Maximum	N/A
Telemedicine Visit	\$5 PCP / \$10 Specialist
PCP Office Visits	\$10 Extra Site OR \$25
Specialist Office Visits	\$50
Preventive Services	100% Covered – No Charge
Physical, Occupational, Speech Therapy	\$50
Chiropractic Services (15 Visits)	\$25
X-rays, laboratory, and other diagnostic tests	No Charge After Deductible
High-tech Imaging (MRI, MRA, CT scan, PET scans)	No Charge After Deductible
Emergency Care	\$200 Copay (Waived if Admitted)
Urgent Care	\$25
Hospitalization (Inpatient)	No Charge After Deductible
Prescriptions	
Low Cost Generic/Generic	\$0 or \$25
Formulary Brand	\$50
Non-Formulary Brand	\$75
Non-Preferred Provider	No Out Of Network Coverage

HEALTH INSURANCE Option 4 \$2,000 PPO

Geisinger All-Access PPO	
Preferred Provider	
Deductible (Single / Family)	\$2,000 / \$4,000
Coinsurance	None
Coinsurance Maximum	N/A
Telemedicine Visit	\$5 PCP / \$10 Specialist
PCP Office Visits	\$25
Specialist Office Visits	\$50
Preventive Services	100% Covered – No Charge
Physical, Occupational, Speech Therapy	\$50
Chiropractic Services (15 Visits)	\$25
X-rays, laboratory, and other diagnostic tests	No Charge After Deductible
High-tech Imaging (MRI, MRA, CT scan, PET scans)	No Charge After Deductible
Emergency Care	\$200 Copay (Waived if Admitted)
Urgent Care	\$25
Hospitalization (Inpatient)	No Charge After Deductible
Prescriptions	
Low Cost Generic/Generic	\$0 or \$25
Formulary Brand	\$50
Non-Formulary Brand	\$75
Non-Preferred Provider	\$10,000 Deductible + 30% Coinsurance Coinsurance Maximum: \$15,000



NETWORK INFORMATION – GEISINGER HMO

The Geisinger Health Plan Network is a regionalized network made up of 42 counties in Pennsylvania, as pictured below. You are not just limited to Geisinger owned providers and hospitals. **When utilizing In-Network the HMO and PPO plans are identical.**

Participating Hospitals for the HMO and PPO include Johns Hopkins in MD, and key hospitals in Philadelphia (ex: University of Pennsylvania, Thomas Jefferson, Fox Chase Cancer Center, Temple, Wills Eye + more.)

Our HMO plan does not require referrals, however it does require you to choose a primary care physician (PCP). You can change your PCP at anytime throughout the year. If you do not have a PCP, one will be assigned for you based on your zip code. **This plan offers no out-of-network coverage.**

If you are traveling anywhere outside of the network and experience a medical emergency, Geisinger will cover you as if you are in-network.

NETWORK INFORMATION – GEISINGER PPO

Geisinger Health Plan’s PPO Network gives you the freedom to choose the doctor, specialist or hospital to provide your care. However, there are advantages to choosing in-network providers such as lower copays & deductibles.

To locate a participating doctor or facility, visit www.thehealthplan.com or call **1-800-447-4000**.

Rating Areas and Service Counties

Geisinger
Health Plan



DENTAL INSURANCE

There will be no changes to your current dental plan. Dental coverage will continue to be provided through Delta Dental.

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

You may select dentists either in or out of the network. However, if you utilize a participating dentist, you will receive greater discounts and your out-of-pocket expenses will be lower. For out-of-network services, you may be balance billed for the difference between Delta Dental's allowance and the provider's charge.

To register with an account, locate a dentist, or obtain benefit information, please visit www.deltadentalins.com. Customer Service: 800-932-0783



Delta Dental PPO	
Deductible (Does Not Apply to Preventive Care)	\$50 Individual / \$150 Family
Maximum Benefit	\$1,500 In-Network / \$1,000 Out-Of-Network
Preventive Care (Exams, Cleanings, X-rays, Sealants)	100%
Basic Care (Fillings, Simple Extractions, Endodontics, Periodontics)	80%
Major Care (Oral Surgery, Crowns, Inlays, Onlays, Cast Restorations, Prosthodontics)	50%
Orthodontia (Dependent Children to age 19)	50%
Orthodontia Maximum	\$1,000 Lifetime

VISION INSURANCE

Vision coverage will continue to be provided through Vision Benefits of America (VBA) and there are no changes to this coverage.

This vision plan allows you a 12-month frequency for exams, lenses, contact lenses, and frames.

The choice of provider is yours, but there are advantages to choosing in-network providers such as reduced out-of-pocket expenses.

Contact VBA: 1-800-432-4966 or www.vbaplans.com



VBA		
Frequency of Service	Vision Exam Lenses Frames	12 months
Benefits	In Network (Amount Covered)	Out of Network (Amount Reimbursed)
Vision Exam	100%	\$40
Materials Copay for Lenses/Frames	\$20 Copay	n/a
Clear Standard Lenses (Single, Bifocal, Trifocal)	100%	\$30, \$40, \$60
Frames	Approximately \$150 Retail Allowance	\$50
Elective Contacts (In lieu of eyeglasses)	\$100 Allowance	\$100
Medically Necessary Contacts	100% (Requires Prior Approval)	\$300

PAYROLL CONTRIBUTIONS (24 Pays)

MEDICAL \$5,000	HMO	PPO
Employee	\$72.33	\$101.59
Employee + Spouse	\$408.48	\$492.24
Employee + Child	\$345.23	\$416.01
Employee + Children	\$368.72	\$444.33
Family	\$431.99	\$520.57

MEDICAL \$2,000	HMO	PPO
Employee	\$119.43	\$146.15
Employee + Spouse	\$513.19	\$592.28
Employee + Child	\$433.73	\$500.55
Employee + Children	\$463.24	\$534.63
Family	\$542.73	\$626.36

DENTAL	Per Pay Deduction
Employee Only	\$2.00
Employee + Spouse	\$13.33
Employee + Child(ren)	\$12.90
Family	\$20.24

VISION	Per Pay Deduction
Employee Only	\$0.50
Employee + Spouse	\$4.34
Employee + Child(ren)	\$4.34
Family	\$4.34

DISABILITY INCOME INSURANCE

Keystone College provides full-time employees with short-term and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

At Keystone College, we want to do everything we can to protect you and your family. That's why Keystone College pays for the full cost of long-term disability insurance—meaning that you owe nothing out of pocket. You also have the option to purchase short-term disability insurance.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits. **This insurance will continue to be offered by Mutual of Omaha.**

If you waived STD as a new hire, you can elect the coverage at open enrollment without any medical questions asked. (No Evidence of Insurability Required).

	VOLUNTARY Short-Term Disability	EMPLOYER PAID Long-Term Disability
Benefits Begin	On 8 th Day	On 61 st Day
Benefits Payable	For 8 Weeks	To Age 70
Percentage of Income Replaced	60%	60%
Maximum Benefit	\$1,300 Weekly	\$6,000 Monthly



EMPLOYEE ASSISTANCE PROGRAM

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your FREE Employee Assistance Program (EAP) can be the answer for you and your family. With this program you have access to EAP Professionals 24-7 for support with emotional well-being, family & relationships, legal & financial matters, healthy lifestyles, work & life transitions.

- Includes 3 face-to-face counselor sessions per household per calendar year
- Legal assistance & financial resources including online will preparation
- Resources for substances use and other addictions
- Dependent and elder care resources
- Visit www.mutualofomaha.com/eap or call 800-316-2796 for more information.

BASIC LIFE INSURANCE



Life insurance can help provide for your loved ones if something were to happen to you. Keystone College provides full-time employees with 2x Base Salary to Max \$100,000 in group life and accidental death and dismemberment (AD&D) insurance.

Keystone College pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information. **Effective June 1, 2025 this insurance will continue to be offered by Mutual of Omaha.**

VOLUNTARY LIFE INSURANCE

While Keystone College offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through 24 payroll deductions. You can purchase coverage for yourself or for your spouse in \$10,000 increments up to 5x your annual salary or a maximum of \$500,000. The employee Guaranteed Issue (GI) amount is \$150,000 and the spouse GI amount is \$30,000. Any amount elected above the GI requires an Evidence of Insurability form to be completed. The chart below outlines the monthly costs of purchasing additional coverage.

Monthly Cost for Every \$1,000 of Employee and Spouse Life Insurance Coverage											
Age	<25	25-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life	\$0.05	\$0.06	\$0.09	\$0.10	\$0.15	\$0.23	\$0.43	\$0.65	\$0.94	\$1.64	\$2.06
AD&D	\$.02	\$.02	\$.02	\$.02	\$.02	\$.02	\$.02	\$.02	\$.02	\$.02	.02
Dependent Children	Dependent Child in \$1,000 increments to \$10,000 (\$2,000 minimum). \$.071/\$1,000 of benefit plus \$.02 per \$1,000 AD&D.										

VOLUNTARY CRITICAL ILLNESS



Critical Illness coverage provides a lump sum cash benefit in the event you, or a covered family member, are diagnosed with a critical illness. **If you waived Critical Illness as a new hire, you can elect the coverage at open enrollment without any medical questions asked. (No Evidence of Insurability Required).**

	For You (Employee)	Spouse	Child(ren)
Flat Benefit	\$10,000	\$10,000	Automatic \$3,000
Guarantee Issue Amount	\$10,000	\$10,000	Automatic \$3,000

- Covers:**
- Heart Attacks
 - Stroke
 - Cancer (Invasive)
 - Acute Respiratory Distress Syndrome
 - Major Organ Transplant
 - Bone Marrow Transplant
 - Cerebral Palsy
 - And others

Age (Employee or Spouse Rates)	Premium Amount (24 pays)
0-29	\$1.10
30-39	\$1.95
40-49	\$4.40
50-59	\$9.35
60-69	\$19.65
70-79	\$36.40
80+	\$49.80

VOLUNTARY ACCIDENT

Voluntary Benefit Offering – **Join at Open Enrollment; no medical questions required.**

Accident coverage provides a lump sum cash benefit for injuries you or an insured family member sustain as a result of an accident. This benefit can be used to pay out-of-pocket medical expenses.

- Examples of Lump Sum Reimbursements related to an accident: Emergency Room Visit \$150, Urgent Care Center \$100, Physician Office Visit \$75, Inpatient Admission \$1,000

Accident coverage helps fill the gaps (time off work/living or medical expenses) left by traditional health insurance coverage and can help give you and your family the added protection needed so you can concentrate on what matters – recovery and healing.

Coverage Tier	Premium Amount (24 pays)
Employee	\$3.98
Employee/Spouse	\$6.06
Employee/Child(ren)	\$7.69
Family	\$10.16

VOLUNTARY HOSPITAL INDEMNITY



A hospital indemnity insurance policy supplements your medical coverage and provides a cash benefit for hospital related fees you or an insured family member sustain as a result of being hospitalized. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work. **Join at Open Enrollment; no medical questions required.**

BENEFITS	AMOUNTS
Admission benefits are payable up to a combined total of 2 days per policy year and are not payable on the same day; Confinement benefits are payable up to a combined total of 30 days per policy year unless otherwise noted and are not payable on the same day as Hospital/ICU benefits.	
Hospital Admission	\$1,000 per admission
Daily Hospital Confinement	\$100 per day
ICU Admission	\$2,000 per admission
Daily ICU Confinement	\$200 per day
Daily Newborn Nursery Care Confinement (Up to 2 days per policy year)	\$75 per day

Coverage Tier	Premium Amount (24 pays)
Employee	\$8.06
Employee/Spouse	\$18.48
Employee/Child(ren)	\$11.09
Family	\$22.17

HEARING DISCOUNT PROGRAM

The Hearing Discount program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

FLEXIBLE SPENDING ACCOUNT (FSA)



Paying for health care can be stressful. That's why Keystone College offers an employer-sponsored flexible spending account (FSA). The FSA will continue to be administered by AmeriFlex.

WHAT ARE THE BENEFITS OF AN FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money.** Allows you put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible.** You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. **If you do not use it, you lose it.** You should only contribute the amount of money you expect to pay out of pocket that year.

2025 MEDICAL FSA CONTRIBUTION LIMIT & ROLL OVER

Up to \$3,300. If any balances remain at the end of the year up to \$**500 or \$660** may be rolled over into the new plan year.

FSA Expense Examples: copayments, deductible expenses, prescription medications, laser eye surgery, eyewear, hearing aids, orthodontics, etc.

WHAT IS A DEPENDENT CARE FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is \$5,000 (or \$2,500 if married and filing separately). If any balances remain at the end of the grace period they will be forfeited.

Qualified dependent care is supervisory care for your dependents up to age 13 or the care of a mentally or physically disabled dependent. A general rule is that the dependent care must be necessary so that you and/or your spouse can work outside the home.

HOW DO I ENROLL?

Complete your election on Keystone College online benefit portal, Flock. Even if you signed up last year, **you must re-enroll for 2025.**

HOW DO I FILE A CLAIM?

Medical FSA – Claims can be filed using a manual form or via the AmeriFlex website. Please remember to retain your receipts in the event you are asked to substantiate your expenses.

Dependent Care FSA – Claims can only be submitted for dollars that have been payroll deducted. *You are not able to pay in advance for dependent care.*

CONTACT AMERIFLEX: www.myameriflex.com or 888-868-3539

Legal Notices



Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an employer's control group or for other reasons. In this regard, the following laws may be applicable.

The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Benefits for Adopted Children

The Employer group health and dental plans will extend benefits to Dependent children who are adopted or placed with a Participant for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants.

Continuation of Coverage under Cobra

OneSource Benefits is required to notify all employees of their right to continue coverage of medical benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) law. This benefit is extended to employees and their eligible dependents at the time of a qualifying event.

Family Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to employers with 50 or more employees within a 75 mile radius. FMLA also requires an employee to have worked a certain number of hours and months in order to be eligible. Where applicable this law provides certain rights and options relating to Group Health Plan coverage. It requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. Such family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's Spouse, child, or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform his or her job.

In 2008 the FMLA was expanded regarding an eligible employee's parents or immediate family members being called to active military duty status or in active military duty: first, the events for triggering family leave now include "qualifying exigencies" of covered service members. Second, with respect to care for covered service members with a serious injury or illness, eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period.

GINA

The Genetic Information Nondiscrimination Act (GINA) applies to certain health plans effective for Plan Years beginning on or after May 21, 2009. GINA states that health benefit plans may not discriminate on the basis of genetic information with respect to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by a "covered entity" or "business associate" as defined under HIPAA. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

Where GINA applies, genetic information is treated as protected health information (PHI) under HIPAA. Under GINA, the plan must provide that an employer cannot request or require that the individual reveal whether genetic testing has or has not occurred relating to that individual, nor can an employer require an individual to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums. Covered entities and business associates may not use genetic information for restricted underwriting purposes. "Restricted underwriting purposes" include underwriting activities involving eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Grandfathered Plan Notice

The coverage outlined in this guide may be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HIPAA Portability and Privacy Requirements

Where the Health Insurance Portability and Accountability Act ("HIPAA") applies to a Component Benefit Plan, such Plan shall be operated in accordance with such law. Where the Genetic Information Nondiscrimination Act ("GINA") applies, genetic information is treated as protected health information ("PHI") under HIPAA effective for Plan Years beginning on or after May 21, 2009.

Federal regulations describe how medical information about you may be used and disclosed and how you can get access to this information. For purposes of administering the plans, information may be shared between OneSource Benefits and the plan administrators.

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), is effective as to health plans for Plan Years beginning on or after October 3, 2009 (and for collectively bargained plans, the later of January 1, 2010, or the date on which the last collective bargaining agreement terminates). The MHPAEA generally requires that, where the employer employs more than fifty employees and its health plan provides for mental health and substance abuse benefits, parity is required between mental health/substance abuse benefits and medical/surgical benefits offered under a Group Health Plan. Therefore, financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, coinsurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars or scope or duration of treatment may not be substantially more limited than for medical/surgical benefits provided.

Michelle's Law

Michelle's Law applies to Group Health Plans effective for Plan Years beginning on or after October 9, 2009. Michelle's Law states that health benefit plans must provide extended coverage to a Participant's Dependent, who as a full-time student in a postsecondary educational institution would otherwise lose coverage because of taking medically-necessary leave due to a serious illness or injury. This extension is required for up to twelve (12) months or, if earlier, the date the coverage would otherwise end under such component benefit plan.

Newborns' and Mothers' Health Protection Act

Group Health Plans and health insurance insurers offering group insurance 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 normal 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 the previously discussed periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance insurer for prescribing a length of stay not in excess of such periods.

Notice of HIPAA Special Enrollment Rights

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Many states provide coverage to uninsured children whose family income falls under a certain level. These programs are known as the state's Child Health Insurance Program (CHIP). Please refer to the attached Notice for important information about your rights under the CHIPRA Act.

Special Enrollment Rights

HIPAA requires we notify you of your right to enroll in our employer sponsored group health plan under its special enrollment provision if you acquire a new dependent, or you or an eligible dependent decline coverage under our Plan because of alternative coverage and later lose such coverage due to certain qualifying reasons.

Legal Notices



HIPAA provides you with special enrollment rights in the following situations.

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.
- 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, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If your dependent's Medicaid or state Child Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends.
- If you or your dependent becomes eligible for premium subsidy under Medicaid or CHIP, you may in the future be able to enroll you or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends.

Notice of Patient Protections

This Company's group health plan may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact human resources or go to the insurer's website. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the group health plan or the insurer 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact human resources or go to our insurer's website.

Section 111

Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Uniformed Service Employment and Reemployment Rights Act Coverage

Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

Women's Health and Cancer Rights Act of 1998

As required by the Department of Labor and the Department of Health and Human Services, OneSource Benefits is providing this notice about the Women's Health and Cancer Rights Act of 1998. This notice serves as the annual notice required by the Department of Labor. The Women's Health and Cancer Rights Act of 1998 provides certain benefits for mastectomy-related services. These benefits include coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of the mastectomy, including lymph edema.

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

Medicare Part D Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [INSERT GROUP] 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 prescription drug coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone who has 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. [INSERT GROUP] has determined that the prescription drug coverage offered by our health plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and therefore is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [INSERT GROUP] coverage will not be affected. The prescription drug coverage that is offered through [INSERT GROUP] does not have an annual deductible. Participants are responsible for copayments that vary by the drug type and whether the prescription is filled at a retail pharmacy or through mail order.

If you do decide to join a Medicare drug plan and drop your current [INSERT GROUP] prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back, if outside of open enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with [INSERT GROUP] and don't join a Medicare prescription 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 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 on the following page for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [INSERT GROUP] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 March 17, 2025. 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.flmedicaidtprecovery.com/flmedicaidtprecovery.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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>

TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp / Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p>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</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p>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)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since March 17, 2025, 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