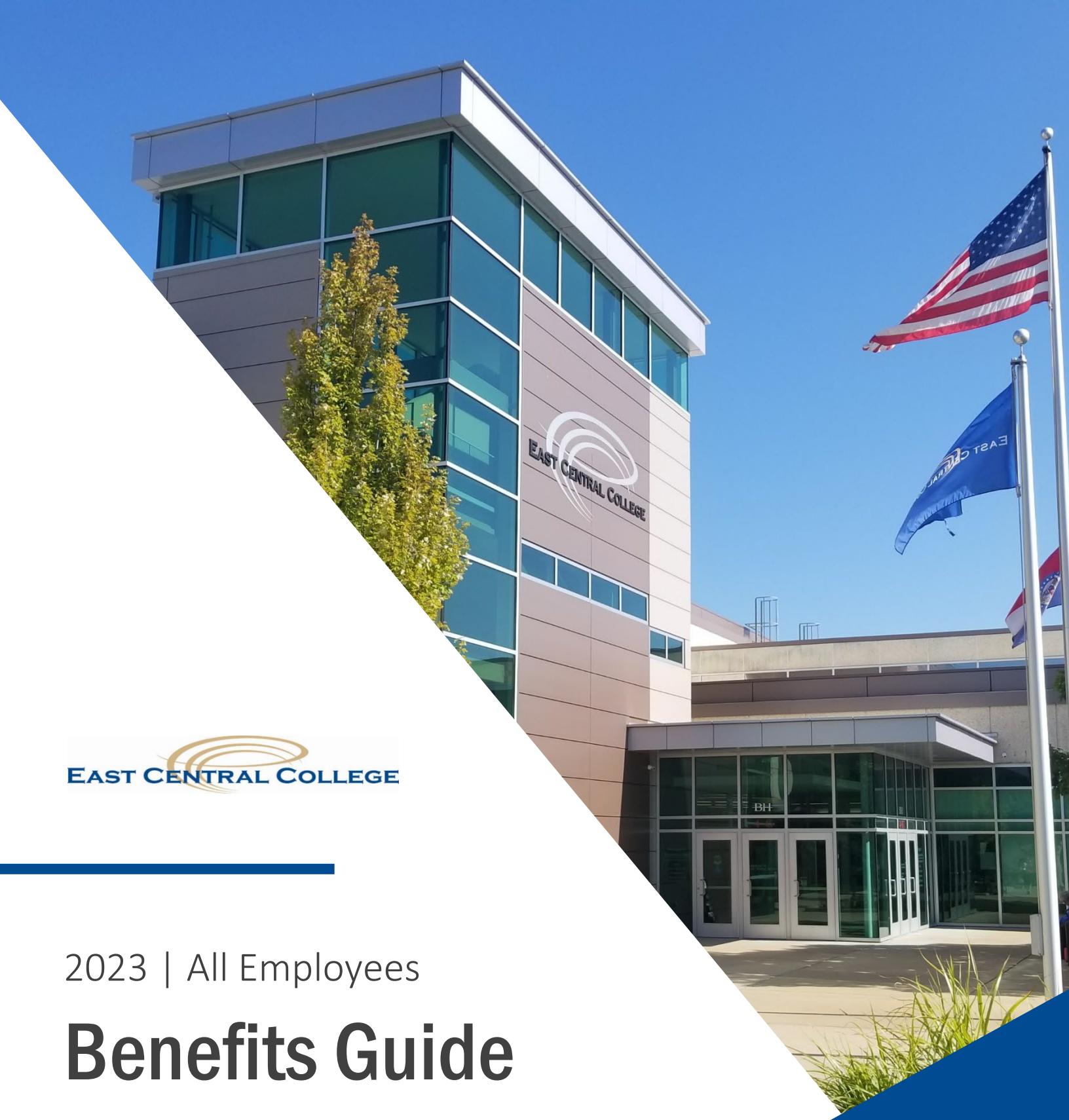


EAST CENTRAL COLLEGE

2023 | All Employees

Benefits Guide

Your Benefits, Your Choice

Inside

Welcome!

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

We encourage you to read this guide, share it with your family members, and ask any questions you may have.

How to Enroll

Current Employees: Open Enrollment, which usually occurs between mid-November and early December, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries. **All employees must enroll in benefits, even if you have no changes for 2023.**

New Hires: Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverages.

Enroll through eCentral Portal:
Enroll in your benefits by logging into your eCentral account. Once you are logged in click Employees > Human Resources > Benefits and follow the prompts listed.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event.

Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- 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

Questions? Contact HR

Human Resources	Phone	Email
Kim Aguilar, HR Generalist	636-584-6710	kimberly.aguilar@eastcentral.edu
Carrie Myers, HR Director	636-584-6712	carrie.myers@eastcentral.edu

Eligibility

Employee Eligibility

All full-time employees working 40 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision and Basic Life:** Medical, Dental, Vision and Basic Life coverages will take effect on the first of the month following the date of hire.
- **Other Coverages:*** All other coverages will take effect on the first of the month following the date of hire.

***IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

- **Medical, Dental, Vision:** Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.
- **Other Coverages:** Employees enrolled in Voluntary Life/AD&D coverage also have the option to enroll their Dependent Spouse and Dependent Children. It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. See page 9 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please refer to the policy certificate or HR for more information.

Definition of "Eligible Dependents"

The below definitions refer to **Medical, Dental, and Vision Coverages**.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- The employee's dependent children until the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Employee Contributions

Medical	PPO Plan (BAC/BPS)		HSA Plan (BAC/BPS)	
	BAC	BPS	BAC	BPS
Employee Only	$69.92	$26.12	$0.00	$0.00
Employee + Spouse	$1,184.14	$1,096.04	$449.20	$382.98
Employee + Child(ren)	$978.24	$898.00	$308.74	$247.90
Family	$2,000.72	$1,877.60	$962.80	$868.40

Dental	
Employee Only	$0.00
Employee + Spouse	$32.80
Employee + Child(ren)	$72.10
Family	$107.92

Vision	
Employee Only	$0.00
Employee + Spouse	$4.04
Employee + Child(ren)	$4.50
Family	$8.72

Life/AD&D	Basic	Term
Employee Only	100% Company-Paid	100% Voluntary**
Employee + Spouse	N/A	100% Voluntary**
Employee + Child(ren)	N/A	100% Voluntary**
Family	N/A	100% Voluntary**

Disability	Long-Term
Employee Only	100% Voluntary**

****Personalized Rates for Voluntary Coverage:** See HR or pages 9-10 for rates.

Medical

Anthem | 1-800-331-1476 | www.anthem.com

We provide you the option to purchase affordable medical coverage. The below plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Locate an in-network provider near you at www.anthem.com/find-care/ or call 1-800-331-1476.

Medical	Base Plan (BAC/BPS)		HSA Plan (BAC/BPS)	
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network Individual/Family	Out-of-Network Individual/Family
Annual Deductible	$3,500/$7,000	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Employee Responsibility	$2,100/$4,000		$3,000/$5,200	
HRA Paid by College	$1,400/$3,000		$2,000/$4,800	
Coinsurance[1] (% you pay after deductible)	20%	50%	20%	50%
Annual Out-of-Pocket Maximum	$5,000/$10,000	$10,000/$20,000	$7,000/$14,000	$14,000/$28,000
Employee Responsibility	$3,500/$7,000		$3,900/$7,800	
HRA Paid by College	$1,500/$3,000		$3,100/$6,200	
Services	In-Network		In-Network	
Office Visit (Primary Care Physician)	$50		$35 after deductible	
Specialist Visit	$70		$60 after deductible	
Urgent Care	$100		$100 after deductible	
Emergency Room	$450		$400 after deductible	
Prescription Drugs (30-Day Supply / 90-Day Supply)	In-Network		In-Network	
Generic	$15 / $30		Deductible then $15 / Deductible then $30	
Preferred	$40 / $80		Deductible then $40 / Deductible then $80	
Non-Preferred	$75 / $150		Deductible then $75 / Deductible then $150	
Tier 4	25% to $350 / 25% to $350		Deductible then 25% to $350 / Deductible then 25% to $350	
Benefit Cost	Employee-paid			

[1] **Coinsurance** and **copay amounts** shown reflect how much you, as a member enrolled on the plan, would be responsible for paying.

Please review the full plan documents for details. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

AmeriBen

All employees enrolled in medical benefits are automatically enrolled into the HRA, no additional paperwork is necessary.

HRAs provide a tax-free, employer-funded amount of money for health care expenses. This arrangement is a great way to pay for out-of-pocket qualified medical expenses while working to meet your plan deductible.

What Are the Benefits of an HRA?

You may enjoy several benefits from having an HRA:

- **It employer-funded.** Your employer contributes tax-free money to the account.
- **It's a tax-saver.** Contributions made by your employer can be excluded from your gross income, meaning you don't pay taxes on that money.
- **It saves you money.** Reimbursement from your HRA will make it much easier to meet your deductible while taking advantage of a health plan with lower premiums.

How Does the HRA Work?

When you incur qualified medical expenses, you can then be reimbursed for those out-of-pocket costs from your HRA.

1. After incurring medical services, the provider will submit a claim to Anthem.
2. Anthem process the claim and then AmeriBen will process.
3. AmeriBen applies charges to the deductible.
    a. If the deductible has not been met, member is responsible for amount due.
    b. If the deductible has been met, AmeriBen reimburses the provider.
4. AmeriBen creates an Explanation of Benefits and sends to the member.
5. Member reviews EOB and compares with their bill to see their member responsibility.

HRA Recordkeeping

Make sure you retain all receipts, Explanation of Benefits (EOBs) and other documents to ensure that you have the necessary proof to obtain reimbursement from your HRA.

Telemedicine

LiveHealth Online| 1-888-548-3432| livehealthonline.com

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. Using your computer, tablet or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

Telemedicine	
Primary Care/ Mental Health Visit	Base Plan: $50 HSA Plan: $35 after deductible
Specialist Visit	Base Plan: $70 HSA Plan: $60 after deductible
Sydney Telemedicine	PCP/Specialty - PPO: $0/$70 - HSA: $0/$60
Commonly Treated Medical Conditions	Allergies Colds, respiratory problems, flu Ear infections Sore throat Pink eye Urinary tract infections
Mental Health Services	EAP—New Directions, page 12

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

[1] Prescription services may not be available in all states.

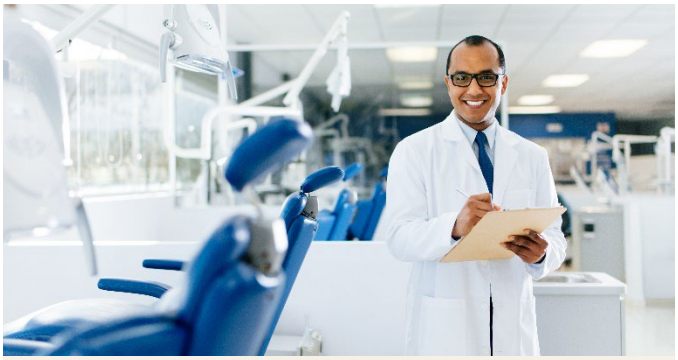
Save time and money with telemedicine.

Telemedicine can provide significant savings over urgent care and emergency room visits. On top of that, you can connect with a doctor from the convenience of home or work, allowing you to avoid the hassle of traveling or sitting in a waiting room.

See more information on page 15.

Dental

Delta Dental | 1-800-335-8266 | www.DeltaDentalMO.com



Locate an in-network provider near you at www.DeltaDentalMO.com or call 1-800-335-8266.

Dental	PPO Dentist	Premier Dentist	Non-Participating Dentist
Annual Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Annual Benefit Max (Per person)	$1,250	$1,250	$1,250
Lifetime Orthodontia Max (Per child up to age 19)	$1,000	$1,000	$1,000
Services[1]	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist**
Preventive Care (Deductible waived)	0% (Covered 100%)	0% (Covered 100%)	0% (Covered 100%)
Basic	90%	80%	80%
Major	60%	50%	50%
Periodontics	90%	80%	80%
Endodontics	90%	80%	80%
Benefit Cost	Employee-paid		

[1] **Coinsurance** reflects how much you, as a member enrolled on the plan, would be responsible for paying after you reach the deductible.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

EyeMed | 1-866-939-3633 | www.eyemed.com

Locate an in-network provider near you at www.eyemed.com or call 1-866-939-3633.

Vision	In-Network
Exam	$10 copay
Retinal Imaging	Up to $39
Lenses	
Single Visions	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Lenticular	$25 copay
Frames	$0 copay; 20% off balance over $150 allowance
Contact Lenses	
Conventional	$0 copay; 15% off balance over $150 allowance
Disposable	$0 copay; plus balance over $150 allowance
Medically Necessary	$0 copay; Paid-in-Full
Frequencies	
Exams	1 per 12 months
Lenses	1 per 12 months
Frames	1 per 24 months
Contact Lenses	1 per 12 months (in lieu of lenses/frames glasses)
Benefit Cost	Employee-paid

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Tax-Advantaged Accounts

FSA | ASIFlex| www.asiflex.com | 1-800-659-3035

	Health Care FSA	Limited-Purpose FSA	HSA	DFSA
Available if you enroll in the …	Base Plan	Base Plan	HSA Plan	Medical plan not required
Eligible for company contributions	No	No	Yes	No
Ability to change your contribution anytime	No	No	Yes*	Yes*
Access only funds that have been deposited	No	No	Yes	No
"Use it or lose it" at year-end	Yes (except $610 rollover)	Yes (except $610 rollover)	No	Yes

*If you experience a qualifying life event.

Flexible Spending Accounts

Health FSA

Pay for health care expenses, such as plan deductibles, copay, and coinsurance.

Annual contribution limit	$3,050

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

Limited-Purpose FSA

Pay for dental and vision expenses.

Annual contribution limit	$3,050

Dependent Care FSA

Pay for dependent care expenses, such as preschool, summer day camp, before and after care for school programs, or child and elder care so you and/or your spouse can work, look for work, or attend school full-time.

Childcare expenses only eligible for children under age 13.

Annual contribution limit	Married (Filing separately)	$2,500
	Single/Married (Filing jointly)	$5,000

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Health Savings Account

HSA

Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family.

	BAC Network	BPS Network
Monthly ECC Contribution	$233.46	$276.70
Total Annual Contribution	$2,801.52	$3,320.40

Annual employee contribution limit	Individual	$3,850
	Family	$7,750
	Catch-up contribution (Age 55 or older)	$1,000

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

Life/AD&D

Anthem | 1-800-331-1476 | www.anthem.com

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if your die or become dismembered due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $50,000
Benefit Cost	Company-paid – No cost to you!

Term Life/AD&D	
Benefit Amount	**Employee:** $500,000 or 5 times annual earnings (in $10,000 increments) **Spouse:** $250,000 (in $5,000 increments)* **Child(ren):** $10,000 (in $1,000 increments)*
Guaranteed Issue Amount[1]	**Employee:** $150,000 **Spouse:** $50,000 **Child(ren):** $10,000
Benefit Cost	Employee-paid

Definition of "Eligible Dependents"

- Spouse – eligibility may terminate at Spouse age 70.
- Child – eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs.

Important – Please Read!

- New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active at Work/eligible status.
- Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefits may be reduced for employees over age 65 per ADEA.

You will still have benefits after age 65, though they will reduce as follows: 35% reduction at age 65; 60% at age 70; 75% at age 75; 85% at age 80 All benefits end at retirement.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

*Dependent elections require employee enrollment and may be limited by employee volume.

[1] If you enroll when first offered, you receive up to the listed amount without having to answer medical questions.

Disability

Anthem | 1-800-331-1476 | www.anthem.com

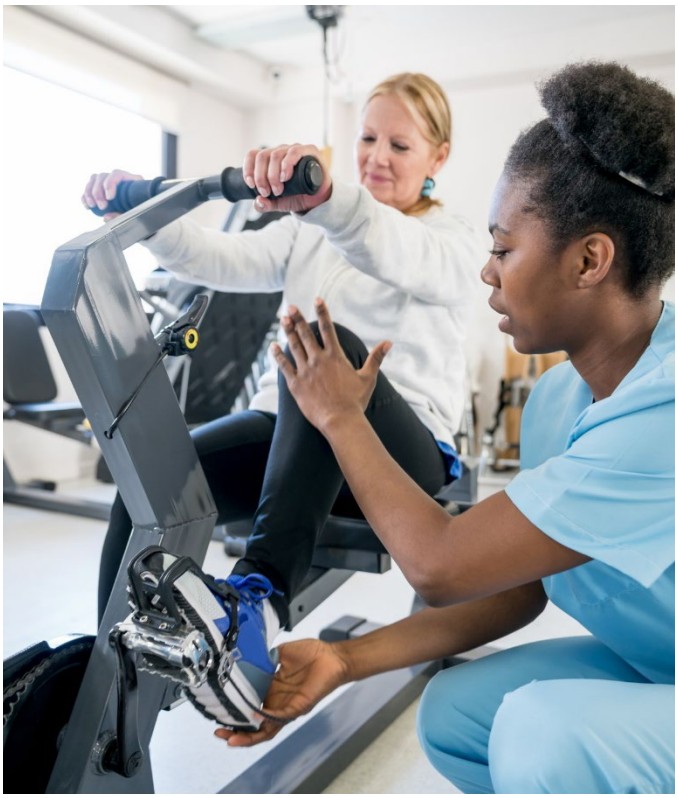
In the event that you become disabled from a **non-work-related injury or illness**, disability income benefits may provide a partial replacement of lost income.

Long-Term Disability	
Benefit Amount	Replaces 67% of earnings, up to $6,000 per month
Benefit Begins	After a period of 90 days
Benefit Duration	ADEA – 65 Reducing Benefit Duration (RBD)
Pre-Existing Condition Limitations	3/12: If you have an injury or illness within the first 12 months of the plan, the carrier will look back to the 3 months prior to your enrollment to see if the condition was "pre-existing."
Benefit Cost	Employee-paid

Important – Please Read!

- New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active at Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



Paid Leave

Personal Leave

Full-time Faculty, Administrative/Professional Staff and Support Staff employees will receive 5 days, or 40 hours, of Personal Leave per year on July 1 of each fiscal year. Full-time Faculty, Administrative/Professional Staff and Support staff employees hired after July 1 of each fiscal year will receive prorated Personal Leave effective the first of the month following the date of hire as follows:

- **July – September:** 5 days/40 hours
- **October – December:** 3.75 days/30 hours
- **January – March:** 2.5 days/20 hours
- **April – June:** 1.25 days/10 hours

Personal Leave is to be used at the discretion of the employee, subject to supervisory approval. Personal Leave that is unused as of June 30th of each fiscal year will be transferred to the employees Earned Sick Leave account if the employee has not already met the maximum sick leave accrual.

Sick Leave

Full-time Administrative/Professional Staff and Support Staff employees will accumulate Sick Leave monthly, at the rate of 16 days, or 10.67 hours per month.

Full-time Faculty will accumulate Sick Leave monthly during the nine-month contract, at the rate of 16 days per year, or 14.22 hours per month, September through May

Vacation Leave

All Full-time Administrative/Professional Staff and Support Staff employees are eligible for three weeks (15 days or 120 hours, at the rate of 10 hours per month) paid vacation annually.

After five years of continuous full-time employment with the College, the annual vacation time will be four weeks (20 days or 160 hours, at the rate of 13.33 hours per month). Maximum vacation accrual is nine weeks (45 days or 360 hours).

Wellness

Work toward healthier habits for you and your wallet.

Employee Assistance Program

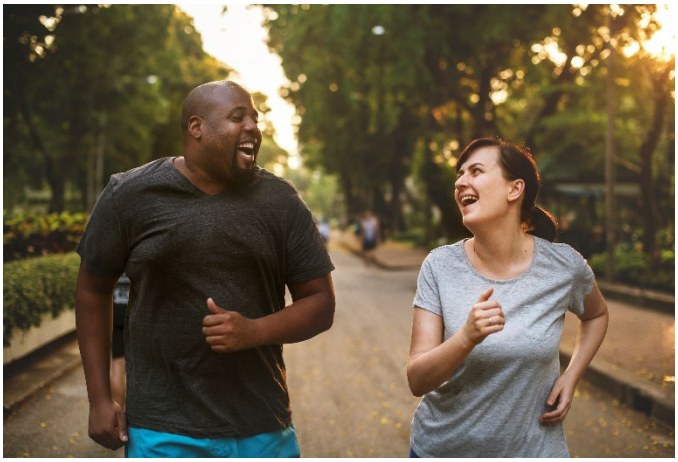
Keeping work and personal life in balance can sometimes be tricky. Stressful situations can affect health, well-being and ability to focus on what's important. That's where this program can help. See more information on pages 15-16.

All employees and covered dependents are eligible for 6 free session per issue through New Directions.

- www.ndbh.com | 800-624-5544
- | Employee Login https://eap.ndbh.com/Home/Login | Login code: **ECC**

Licensed counselors and professionals, can provide safe and confidential support for a variety of needs, such as:

- Stress
- Grief and loss
- Work, marital and relationship conflicts
- Childcare and eldercare concerns
- Mental health
- Physical and sexual abuse
- Substance abuse
- Financial worries
- Legal or financial issues



Wellness Program

In an effort to be proactive about our personal health, as well as the overall health of the company's medical coverage, we are pleased to offer a "Be Well" wellness program.

This is an incentive program that rewards you for your health choices. Participation will earn you points toward paid time off and other prizes.

Why Should I Participate?

- **Save Money:** Participation is voluntary and at no cost to you, however we will reward your good health and wellness habits with paid time off and other prizes.

Wellness Resources

- **Step Challenge** – Track steps to earn rewards
- **Fitness Center** – 3rd Floor / Donald Shook Student Center
- **Flu Shot** – Annually in the Fall
- **Walking Trail** – Union campus, near soccer & softball fields

Additional Benefits

ECC Tuition Waiver

Employees are encouraged to enroll in courses through East Central College using the employee tuition waiver. Tuition waiver benefits are also extended to the immediate family for full-time employees. Full-time and part-time employees, retirees, and immediate family members of full-time employees are eligible for the tuition waiver for East Central College credit courses.

ECC Tuition Reimbursement

Educational assistance benefits are provided to full-time employees. Course must be taken at a regionally accredited college or university and must be applied toward a higher degree than the current highest degree of the employee or a recognized post-secondary certificate or non-degree credential.

Degree related coursework will be reimbursed in accordance with Board Policy up to an amount equal to 100% of the applicable undergraduate or graduate educational fee (tuition) at the University of Missouri-St. Louis. Employee tuition reimbursement covers tuition only and does not apply toward any special fees or book/supply costs.

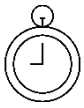
Central Methodist University Tuition Waiver

Full-time employees and members of the immediate family may receive certain waivers of tuition and/or fees for classes taken at Central Methodist University on the East Central College campus in Union, MO. See CMU Policies and Procedures for details.

Undergraduate courses – 100% Tuition waiver for ECC employee, spouse and child dependent.

Graduate courses – 100% tuition waiver for ECC employee, 50% for spouse and no waiver for child dependent. The tuition waiver also includes graduate program courses for ECC full-time employees and spouses.

Retirement



All full-time employees are enrolled in the Public School and Education Employee Retirement Systems of Missouri (PSRS/PEERS) which provide service retirement, disability, and survivor benefits to nearly 130,000 active members and over 65,000 retired Missouri public school teachers, school employees, and their families.

Service Awards

Years of Service Recognized: Awards presented annually by the President of the College for Full-Time and Part-Time at their 5 year service anniversary and every 5 years following. Employees will be honored at a recognition dinner with the Board of Trustees and Administrators prior to October Board meeting each year. Employees receive a Certificate of Recognition and gift.

Retirement Recognition: Awards presented upon retirement.

Anthem

Expanding your virtual care options

Find complete care support, on your time, through the **Sydney Health app**

Visit with a doctor at your convenience

Accessing the care you need, when you need it, matters. That's why our Sydney℠ Health mobile app connects you to a team of doctors ready to help you on your time. There are two secure ways to find no- or low-cost care through our app:

1 Chat with a doctor 24/7 without an appointment

- Urgent care support for health issues, such as allergies, a cold, or the flu.
- New prescriptions for concerns such as a cough or a sinus infection.

2 Schedule a virtual primary care appointment

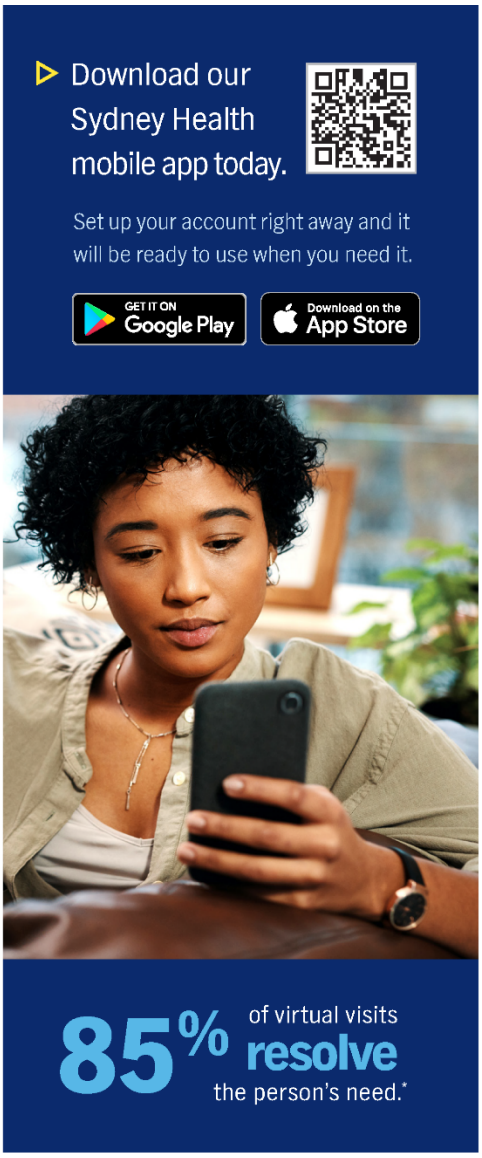
- Routine care, including wellness check-ins and prescription refills.
- Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

Save money and time with virtual care

Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at no or low cost.



*K Health analysis of Q4 2020 visit dispositions.

Sydney Health is offered through an arrangement with CareMarket, Inc., a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield. ©2021-2022.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RT), Healthy Alliance® Life Insurance Company (HALC), and HMO Missouri, Inc. RT and certain affiliates administer non-HMO benefits underwritten by HALC and HMO benefits underwritten by HMO Missouri, Inc. RT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSW), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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When life's a little much,
your EAP has you covered.

Life can be challenging. When your responsibilities start to feel overwhelming and showing up each day seems difficult, it's important to reach out for help. You can lean on your confidential Employee Assistance Program (EAP) for support.

Real support for real life.

A no-cost-to-you benefit from your workplace, your EAP can help you or anyone in your household:

- Receive support when you don't feel like yourself
- Get help with responsibilities that are distracting or stressful
- Improve personal relationships
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life
- Be more present and productive at work
- Grow personal and career skills
- With legal advice or questions
- Assistance with budget or financial concerns

We're always here for you.

Life happens regardless of day or time. We are available 24 hours a day, 365 days a year. Whenever you need to reach out, we are here for you.

Your EAP can help you:

Reduce stress | Cope after crisis | Focus at work | Lead others
Navigate the legal system | Reduce debt | Live a healthier life
Support and improve relationships | Be resilient

How to reach your EAP

Support Line
800-624-5544

Online
eap.ndbh.com

Mobile app
Search for
New Directions
EAP

EAP services are 100% confidential and no-cost to you.

eap.ndbh.com
Code: ECC
800-624-5544

> “EAP has been beneficial in so many ways I don’t know how I would have gotten through without it.”

Download our app.

Search for **New Directions EAP** in your app store.

Available on Google Play | Available on the App Store

Whatever life throws your way, we’re here to help.

Stress, relationships, work and money. These are the most common reasons people reach out to EAP every year. No matter what issues you’re facing, EAP is the perfect first step for you or your household members.

Counseling

Depending on your situation, your preference for help may change. That’s why we offer several different ways for you to get what you need. Counseling is available in a variety of ways:

- Face-to-face
- Online
- Over the phone
- In-the-moment

Legal and financial resources

Navigating finances and/or the legal system can be overwhelming and confusing. Luckily, your EAP can help with services like:

- A no-cost-to-you, 30-minute consultation with a certified financial expert or attorney
- Online tools including budget templates, financial calculators, tax preparation documents, will builder, business agreements and other legal documents
- Emotional support and referrals to help you better manage your legal and financial challenges

Work/Life

Work/Life services can help you tackle your to-do list with specialists who can locate providers, get referrals and find resources for almost anything you and your household needs. You have free access to:

- Personalized consultation with a highly-trained specialist over the phone or through online chat
- Referrals to local providers and resources
- Tip sheets, checklists and other helpful tools

Work/Life topics may include family and caregiving, education, legal and financial, career and work, and health and wellness.

Coaching

Life coaching services are designed to promote self-awareness, clarify visions, values, intentions and goals. This service builds on strengths that you already have to help you set and achieve your goals. With coaching you can:

- Schedule telephonic sessions with one of our coaches
- Work with your coach to establish and meet goals
- Identify resources to keep you on track

Coaching topics may include managing stress, work/life balance, time management, personal challenges, setting and organizing priorities.

Online Services

Our comprehensive website, as well as our New Directions EAP mobile app, make it easy to access information regarding EAP benefits and requesting services. The website and app offer:

- Referrals via online intake
- Mental health toolkits
- Monthly live webinars and other training resources
- Substance use resources
- Resource Library includes webinars, calculators, videos, articles and much more.

Take your first step and call today.

eap.ndbh.com
Code: ECC
800-624-5544

EAPM1037-20210915

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

To find a provider in-network, visit this website and enter your Medical ID information: https://www.anthem.com/find-care/

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		

Take advantage of preventive care.

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Perkspot Discount Program

Through our partnership with Cottingham & Butler, we have access to the PerkSpot Employee Discount Program at no cost to you!

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Who is PerkSpot?

- Online savings resource for employees
- Headquarted in Chicago, IL
- Founded in 2006
- 750+ clients nationwide
- 15 million members
- 30,000+ discount offers

Website Features

- **Recommended for You:** chosen based on your top interests
- **Featured Offers:** hand-selected to help you stretch your dollars
- **Today's Perk Alters:** today's best limited-time sales
- **Popular Savings:** trending offers
- **Categories:** shop by category
- **Local Discounts**: shop by location

Create Your Account

1. Visit https://cottinghambutler.perkspot.com/
2. Click "Create an Account"
3. Enter your Name, Email, Gender, Zip Code and create a Password
4. Sign up for email updates
    a. **Weekly Perks:** Stay up to date on the best discounts and exclusive offers available to you
    b. **theLOOP:** PerkSpot's weekly resource for how to excel in the 21st century workplace. Providing insights into workplace trends, lifestyle practices, and strategies for success
5. Click "Register"
6. Browse discount offers from over 25 categories

Shop for a Variety of Coupons & Deals from these Categories:

- Apparel
- Auto Buying
- Automotive
- Beauty & Fragrance
- Books, Movies, & Music
- Business Perks
- Cell Phones
- Education
- Electronics
- Financial Wellness
- Flowers & Gifts
- Food
- Health & Wellness
- Hobbies & Creative Arts
- Home & Garden
- Home Services
- Insurance & Protection Services
- Jewelry & Watches
- Movie Tickets
- Office & Business
- Pets
- Real Estate & Moving Services
- Sports & Outdoors
- Tickets & Entertainment
- Toys, Kids & Babies
- Travel

Popular Discounted Brands*:

- Avis
- Canon
- Casper
- Columbia
- Dell
- Enterprise
- Holiday Inn
- Home Chef
- HP
- Ray-Ban

**All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com/*

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Annual Required Notices

East Central College
Health Law Notices

Michelle's Law Notice
If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave
Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf of such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only
If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2022. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
A 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

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – 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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
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
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA – 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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-free number for the HIPP program:
1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Disclosures

Women's Health and Cancer Rights Act of 1998
The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

a. Reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphedema.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay
Group health plans and health insurance issuers offering group health 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 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders
A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.61% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date

of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices
Effective Date: March 1, 2013

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The East Central College Group Medical Plan (the "Plan"), which includes medical coverages offered under the East Central College Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures East Central College has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
East Central College is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a

covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at East Central College, 1964 Prairie Dell Rd, Union, MO 63084, (636) 584-6500. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Important Notice from East Central College About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with East Central College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current

coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. East Central College has determined that the prescription drug coverage offered by the East Central College Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current East Central College coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current East Central College coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with East Central College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through East Central College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: [INSERT DATE]
Name of Entity/Sender: East Central College
Contact--Position/Office: Human Resources
Address: 1964 Prairie Dell Rd, Union, MO 63084
Phone Number: (636) 584-6500

APPLIES TO HIGH DEDUCTIBLE HEALTH PLAN ONLY

Important Notice from East Central College About Your Prescription Drug Coverage and Medicare (Non-Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with East Central College 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. East Central College High Deductible Health Plan has determined that the prescription drug coverage offered by East Central College is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the East Central College high deductible health plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from East Central College. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with East Central College, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the East Central College high deductible health plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the East Central College high deductible health plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 East Central College coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current East Central College coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through East Central College changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: November 15, 2022
Name of Entity/Sender: East Central College
Contact--Position/Office: Human Resources
Address: 1964 Prairie Dell Rd, Union, MO 63084
Phone Number: (636) 584-6500