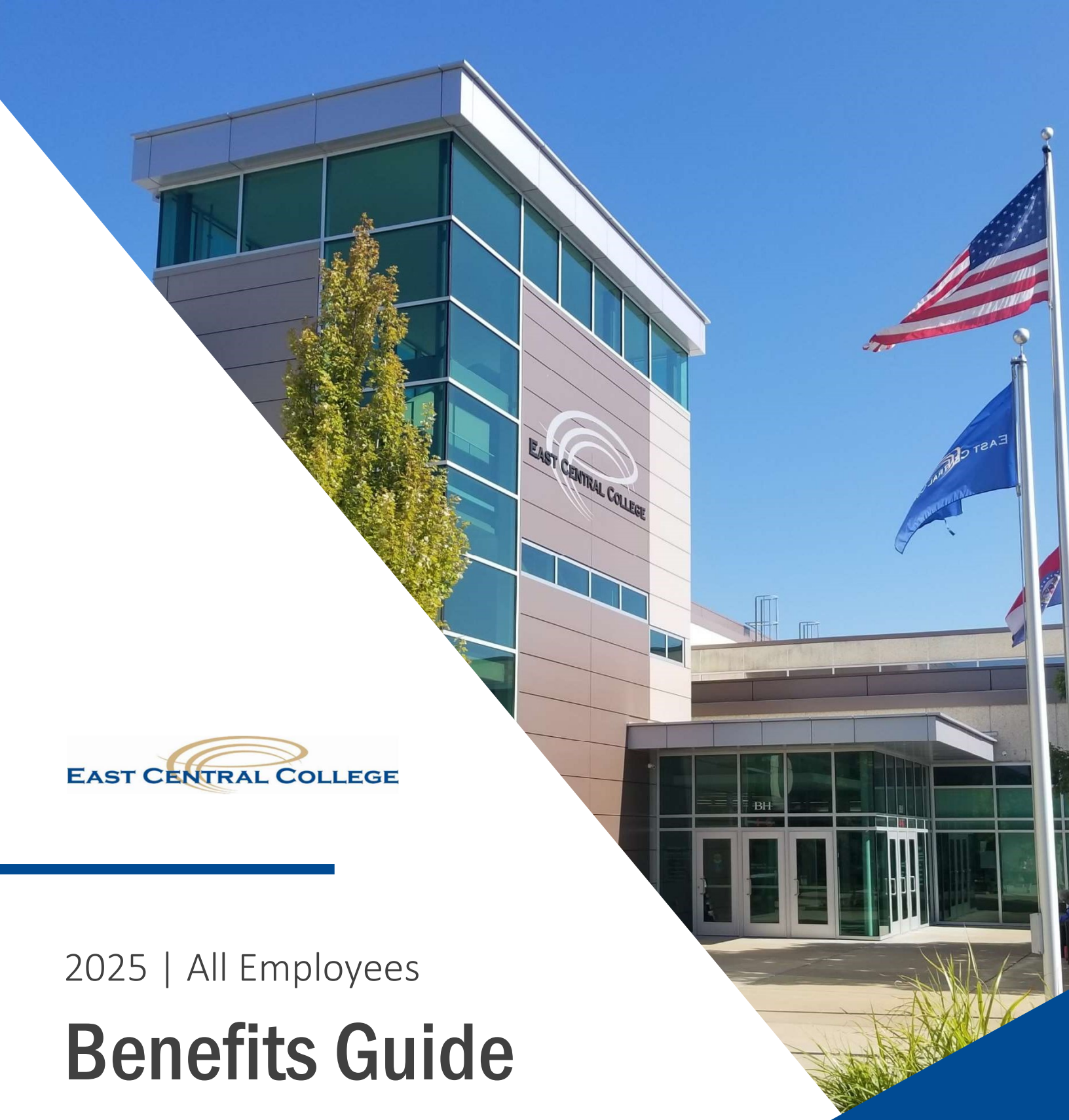


EAST CENTRAL COLLEGE

2025 | All Employees

Benefits Guide

Your Benefits, Your Choice

Inside

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

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 2025.**

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 MyECC Portal:
Enroll in your benefits by logging into your MyECC 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) BAC Network includes BJC BPS Network does NOT include BJC		HSA Plan (BAC/BPS) BAC Network includes BJC BPS Network does NOT include BJC	
	BAC	BPS	BAC	BPS
Employee Only	$87.26	$41.28	$0.00	$0.00
Employee + Spouse	$1,254.50	$1,162.28	$483.46	$414.58
Employee + Child(ren)	$1,038.80	$954.86	$336.36	$273.14
Family	$2,109.80	$1,981.02	$1,020.90	$922.88

Dental	
Employee Only	$0.00
Employee + Spouse	$32.16
Employee + Child(ren)	$70.66
Family	$105.78

Vision*	Full Service	Material Only
Employee Only	$0.00	$0.00
Employee + Spouse	$4.52	$4.00
Employee + Child(ren)	$5.04	$4.44
Family	$9.76	$8.62

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**

*Full-service rate for employees that have dependents on vision, but not on medical. Material only rates for employees and dependents on medical.

****Personalized Rates for Voluntary Coverage:** See HR for rates.

2025 Medical

Anthem | 1-833-363-1429 | 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 1-833-363-1429.

Medical	Base Plan (BAC/BPS) BAC Network includes BJC BPS Network does NOT include BJC		HSA Plan (BAC/BPS) BAC Network includes BJC BPS Network does NOT include BJC	
	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network Individual/Family	Out-of-Network Individual/Family
Annual Deductible	$3,500/$7,000	$3,750/$7,500	$5,000/$10,000	$5,000/$10,000
Employee Responsibility	$2,100/$4,000		$3,300/$5,200	
HRA Paid by College	$1,400/$3,000		$1,700/$4,800	
Coinsurance[1] (% you pay after deductible)	20%	50%	20%	50%
Annual Out-of-Pocket Maximum	$5,000/$10,000	$5,250/$10,500	$7,000/$14,000	$7,250/$14,500
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	
Preventive Services	No Charge		No Charge	
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.

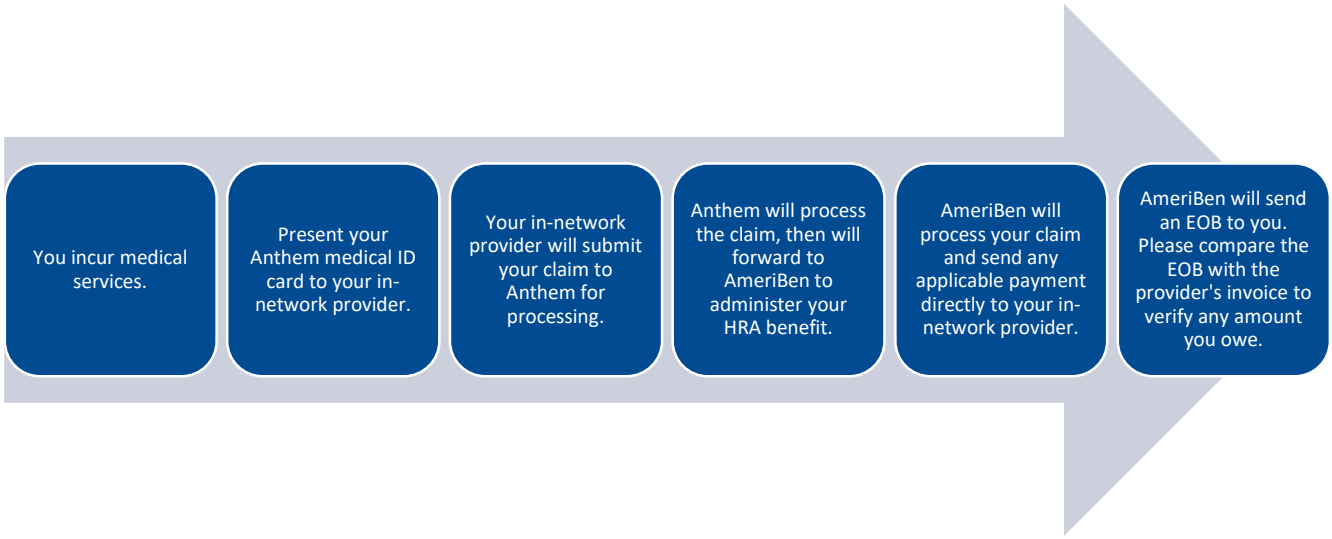
How Does the HRA Work?

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 processes the claim, then forwards the claim for AmeriBen to 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—Lucet Health, 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.

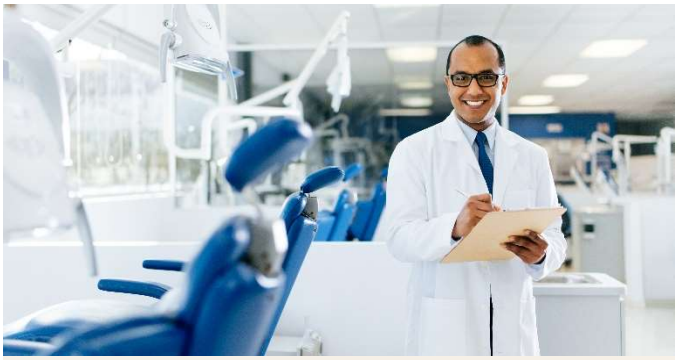
Save time and money with telemedicine.

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

Anthem | 1-833-363-1429 | www.anthem.com



Locate an in-network provider near you at www.anthem or call 1-833-363-1429.

Dental	In Network Dentist	Out of Network Dentist
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Annual Benefit Max (Per person)	$1,250	$1,250
Lifetime Orthodontia Max (Per child up to age 19)	$1,000	$1,000
Services[1]	**In Network Dentist**	**Out of Network Dentist**
Preventive Care (Deductible waived)	0% (Covered 100%)	0% (Covered 100%)
Basic	90%	80%
Major	60%	50%
Periodontics	90%	80%
Endodontics	90%	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

Anthem| 1-833-363-1429 | www.anthem.com

Locate an in-network provider near you at www.anthem.com or call 1-833-363-1429.

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	$3,300

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	$3,300

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	$231.28	$276.70
Total Annual Contribution	$2,801.52	$3,320.40

Annual employee contribution limit	Individual	$4,300
	Family	$8,550
	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 | 1-833-363-1429 | 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 | 1-833-363-1429 | www.anthem.com

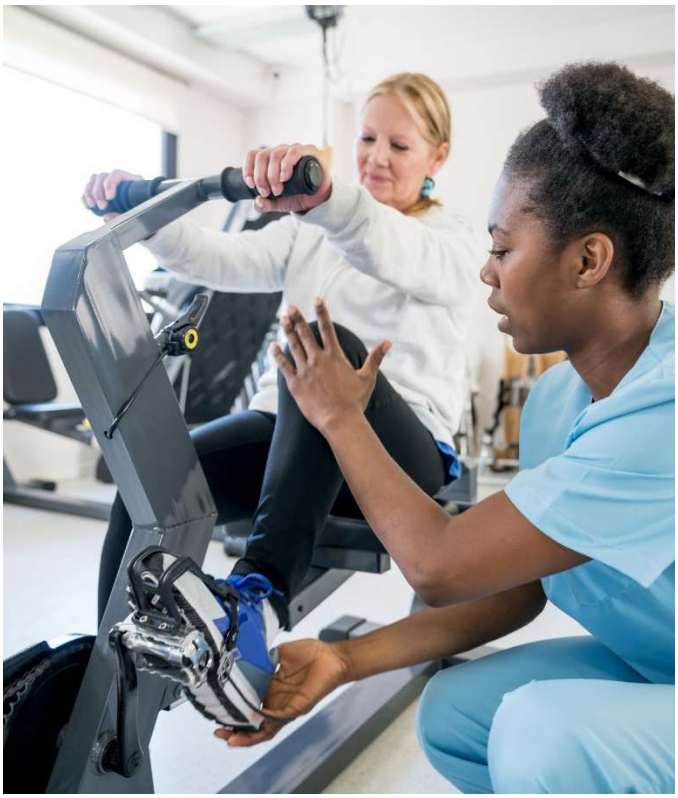
In the event that you become disabled from a **non-work-related injury or illness**, disability income benefits may provide a partial replacement of lost income.

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 – May:** 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 16-17.

All employees and covered dependents are eligible for 6 free session per issue through Lucet Health.

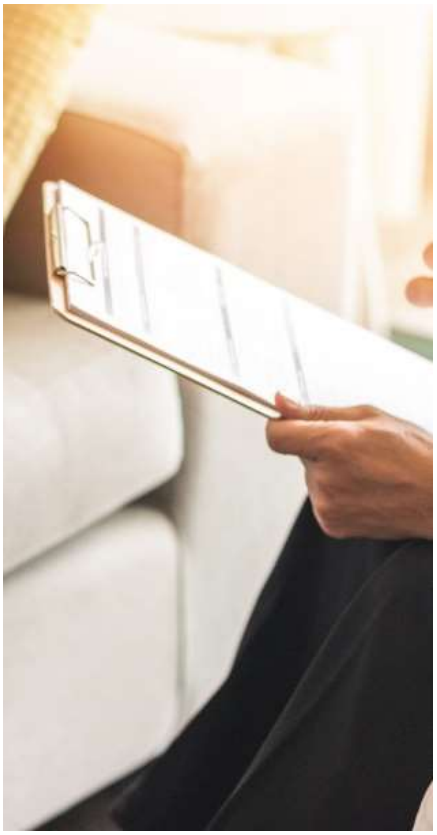
- https://eap.lucethealth.com | 800-624-5544
- Employee Login https://eap.lucethealth.com/Home/Login | Login code: **ECC**

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 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.

Missouri Baptist University Tuition Discount

Full-time employees can enroll in Missouri Baptist University and receive a 20% discounted tuition rate for the Master of Science in Higher Education Leadership program. The tuition rates for the graduate programs are published annually in the University's graduate bulletin.

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.

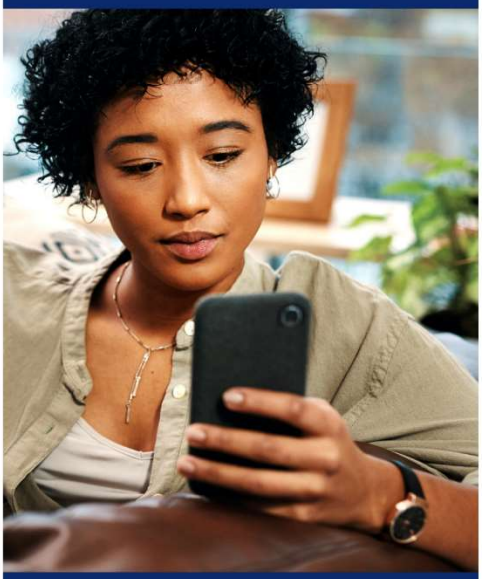
Save money and time with virtual care

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.

Download our Sydney Health mobile app today.

Set up your account right away and it will be ready to use when you need it.

GET IT ON Google Play | Download on the App Store



85% of virtual visits **resolve** the person's need.*

*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. (RTI), Healthy Alliance® Life Insurance Company (HALC), and HMO Missouri, Inc. RTI and certain affiliates administer non-HMO benefits underwritten by HALC and HMO benefits underwritten by HMO Missouri, Inc. RTI 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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Employee Assistance Program

Lucet™ | Employee Assistance Program

Personalized care and resources, *when you need them.*

Whether it's planning for your financial future or beginning to seek mental health resources, your Employee Assistance Program (EAP) is here to help. Available to you and your household members, Lucet's EAP is your first step to resources, counseling and so much more to support your wellbeing.

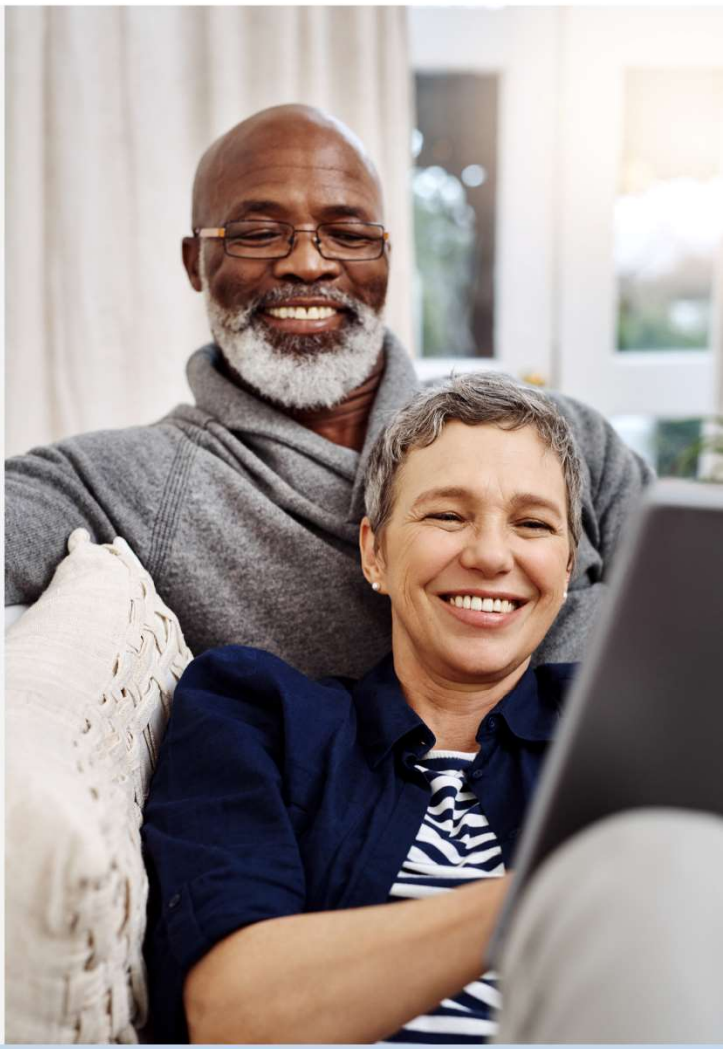
Real support for real life.

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

Lucet | Employee Assistance Program

eap.lucethealth.com

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, the resources you access are confidential so feel safe knowing you can begin addressing any of your personal challenges today.

Counseling

We offer several different ways for you to get what you need. **Counseling is available in a variety of ways at no cost:**

Face-to-Face | Online | Telephonic

Life Coaching

Life coaching services promote self awareness and help you clarify your 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 a qualified coach
- 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 and more.

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
- Resources and tip sheets

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 you and your household needs.

- 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 include family & caregiving, education, legal & financial, career & work, and health & wellness.

Online Services

Our comprehensive website makes it easy to access information regarding EAP benefits and requesting services. **The website and app offer:**

- Referrals via online intake
- Mental health toolkits
- Substance use resources
- Monthly live webinars
- Training resources
- Comprehensive Resource Library

Your well-being is our priority.

Lucet EAP provides confidential support, counseling services and resources to help you overcome life challenges and live a happy, balanced life.

Call 800-624-5544 | Visit eap.lucethealth.com

Your company code: **ECC**

counseling/coaching sessions, per topic, per year.

Scan to learn more at **eap.lucethealth.com**

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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.

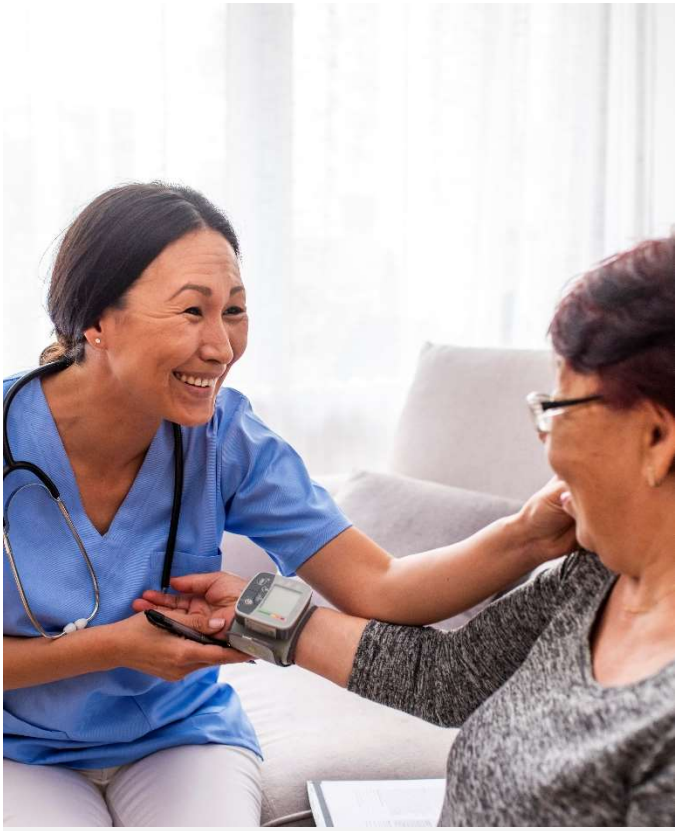
Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary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

Anthem Rewards

Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$25
	Get an annual dental exam	$25
	Get an annual flu shot	$20

Anthem

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Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

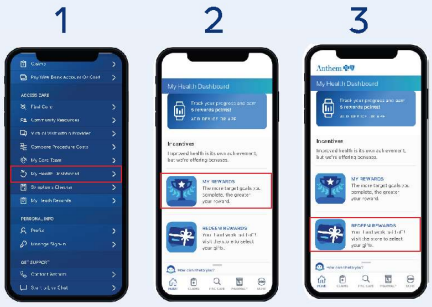
Digital and wellness activities: Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards toward electronic gift cards for select retailers.

1 To view your rewards, open the Sydney Health app or go to **anthem.com**. Next, go to *My Health Dashboard*.

2 Select **My Rewards**.

3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.



Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (lipid) panel.

2 Annual eye exam reward is available if employer provides vision coverage through **Anthem**.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (chronic obstructive pulmonary disease [COPD], coronary artery disease [CAD], asthma, diabetes, and congestive heart failure [CHF]. Rewards include: $20 for program participation and $30 for program completion.

4 Building Healthy Families milestone completion dates: BHF Pregnancy Screener must be completed in first trimester; at least 1 of 6 mini assessments must be completed by one day prior to delivery; postpartum assessment must be completed by 56 days after delivery. Rewards include: $10 for profile completion; $10 for a BHF Pregnancy Screener; $10 for completing at least 1 of 6 mini assessments; $10 for a postpartum assessment.

5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a body mass index (BMI) of 30 or higher.

6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

7 Members may earn rewards for completing quarterly Well-being Coach digital milestones while logging daily check-in activities on the app. Daily check-in reward values: first check-in: $4; next 15 check-ins during first quarter: $4; 25 check-ins during second through fourth quarters: $4 each quarter. Log in to Sydney Health or **anthem.com** to download the Well-being Coach digital app. Well-being Coach is provided by Lark Health.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023

We encourage you to actively participate in your rewards program. Rewards earned should be redeemed before the end of the current plan year. Unused rewards are forfeited three months after the end of your plan year. Make sure to redeem them before then.

All preventive care activities are claims-based, which means your completion is determined when a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse/domestic partner. Members must be active on the plan and their activity must take place during the plan year. A subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.

The reward amount you receive may be considered income to you and subject to state and federal taxes in the tax year it is paid. You should consult a tax expert with any questions regarding tax obligations.

Electronic gift card availability may vary. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com or open the Sydney Health app to explore the electronic gift card options available to you.

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 Employee Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. 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 a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

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 July 31, 2023. V 0.2.0. 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:
https://dhss.alaska.gov/dpa/Pages/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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
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
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

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
HIPP Phone: 1-800-967-4660

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/agencies/dms

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.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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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
Email: HHSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
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: https://www.hhs.nd.gov/healthcare
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
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
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 July 31, 2023, 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 ❖

Notice Regarding Wellness Program

Integrated Health21 is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You will also be asked to complete a biometric screening, which will include a blood test for cotinine (nicotine use),

total cholesterol, HDL, LDL, triglycerides, glucose, BUN, creatinine, uric acid, SGOT, SGPT, alk phos, protein, albumin, total bilirubin, globulin, calcium, LDH, GGT. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and East Central College may use aggregate information it collects to design a program based on identified health risks in the workplace, Integrated Health21 will never disclose any of your personal information except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Integrated Health21 screening personnel in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personal records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. ❖

Patient Protection Notice

If the East Central College Employee Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

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

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

Newborns' and Mothers' Health Protection Act

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 9.12% 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 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 no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

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

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 HRA, dental and flexible spending account 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, 636-584-6710.

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, 636-584-6710. 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, 636-584-6710. 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, 636-584-6710. 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, 636-584-6710. 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, 636-584-6710 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, 636-584-6710. 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 Employee Health Plan 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: 10.13.2024
Name of Entity/Sender: East Central College
Contact--Position/Office: Human Resources
Address: 1964 Prairie Dell Rd, Union, MO 63084
Phone Number: 636-584-6710 ❖