Capital University

2023 BENEFITS GUIDE

August 1—December 31, 2023

Welcome

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your registered domestic partner (DP) and/or their children, where applicable by state law
- Your children who are your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **New Hires:** You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following your date of hire.

  If you fail to enroll on time, you will **NOT** have benefits coverage (except for company-paid benefits).
- **Open Enrollment:** Changes made during Open Enrollment are effective August 1, 2023- December 31, 2023.

When Coverage Ends

- Employees: Coverage ends the date employment ends.
- Dependents: Coverage ends the date employment ends. In the event a dependent child turns 26 and ages off the plan, their coverage would end at the end of the month in which they turn 26.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualified life event during the year. Following are examples of the most common qualified life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, DP, or child
- You lose coverage under your spouse's/DP's plan
- You gain access to state coverage under Medicaid or CHIP

Making Changes

To make changes to your benefit elections, you must contact Human Resources within 31 days of the qualified life event (including newborns). Be prepared to show documentation of the event such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

Required Information—*When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

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Enrollment

Go to http://benefits.plansource.com There you will find detailed information about the plans available to you and instructions for enrolling.

Medical

We are proud to offer you a choice of medical plans that provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Following is a brief description of each plan.

Leading Edge SPP / PPO Plan

This plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the network.

- The plan pays the full cost of qualified in-network preventive health care services.
- You pay the full cost of non-preventive health care services until you meet the annual deductible. You may also have to pay a fixed dollar amount (copay) for certain services.
- Once you meet the deductible, you pay a percentage of certain health care expenses (coinsurance) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all qualified health care services for the rest of the year.

Leading Edge SPP / HDHP / HSA

The High-Deductible Health Plan (HDHP) works similarly to a traditional PPO:

- You may see any health care provider and still receive coverage, but will maximize your benefits and lower your out-of-pocket costs if you see an in-network provider.
- The plan pays the full cost of qualified in-network preventive health care services.
- You pay the full cost of non-preventive health care services until you meet the annual deductible.
- Once you meet the deductible, you pay a percentage of your health care expenses (coinsurance) and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all qualified health care services for the rest of the year.

The HSA

The HDHP comes with a type of savings account called a health savings account, or HSA. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

Here's how the HSA works:

- You contribute pre-tax funds to the HSA through automatic payroll deductions.
- In addition, we will contribute $1,000 annually to your HSA if you enroll in employee-only coverage and $2,000 annually if you enroll yourself and one or more family members.

HSA Contribution Limit	2023
Employee Only	$3,850
Family (employee + 1 or more)	$7,750
Catch-up (age 55+)	$1,000

You can withdraw HSA funds tax-free to pay for current qualified health care expenses, or save them for the future, also tax-free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Important Notes:

- You must meet certain eligibility requirements to have an HSA: You must
- a) be at least 18 years old, b) be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- For a complete list of qualified health care expenses, refer to IRS Publication 502.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA

Medical

We are proud to offer you a choice of medical plans. Following is a high-level overview of the coverage available.

Key Medical Benefits	Leading Edge SPP PPO Plan	Leading Edge SPP HDHP / HSA
Deductible (per calendar year)		
Individual / Family	$1,000 / $2,000	$3,000 / $6,000
Out-of-Pocket Maximum (per calendar year)		
Individual / Family	$3,000 / $6,000	$5,000 / $10,000
Company Contribution to Your Health Savings Account (HSA) (per calendar year; prorated for new hires/newly eligible)		
Individual / Family	N/A	$1,000 / $2,000
Covered Services		
Office Visits (physician/specialist)	$25 / $50 Copay	15%*
Virtual Visits	$25 Copay	15%*
Routine Preventive Care	No charge	No charge
Outpatient Diagnostic (lab/X-ray)	15%*	15%*
Complex Imaging	15%*	15%*
Chiropractic	$25 Copay	15%*
Ambulance	15%*	15%*
Emergency Room	$250 Copay	15%*
Urgent Care Facility	$50 Copay	15%*
Inpatient Hospital Stay	15%*	15%*
Outpatient Surgery	15%*	15%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3)		
Retail Pharmacy (30-day supply)	$10 / $25 / $50 / 25% to $135	$10 / $40 / $60
Mail Order (90-day supply)	$25 / $75 / $125	$25 / $100 / $150

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents

The Leading Edge Savings Plus Plan

The Savings Plus Plan is a program developed to minimize members out of pocket expenses through competitive pricing negotiation. This focused health benefit payment program applies to all inpatient and outpatient facility services as well as a limited number of surgical and medical services. These SPP services are identified in your plan booklet. Under the SPP, the provider's reimbursement level for these services will be a percentage of Medicare.

Dental

We are proud to offer you a dental plan

Delta Dental of Ohio Point-of-Service (POS) Plan

With the POS plan, you select a primary dentist from the participating network of providers who will coordinate your health care needs. Services received outside of the POS network may be covered but it's your responsibility to work with that office and your carrier to complete the insurance paperwork.

Following is a high-level overview of the coverage available.

Key Dental Benefits	Delta Dental POS	
	In-Network	Out-of-Network
Deductible (per calendar year)		
Individual / Family	$50 / $50	$50 / $150
Benefit Maximum (per calendar year; Preventive, Basic, and Major Services combined)		
Per Individual	$1,000	$1,000
Covered Services		
Preventive Services	No charge	No charge
Basic Services	20%	20%
Major Services	50%	50%
Orthodontia (Child only)	50% to $1,000 lifetime maximum	50%

Coinsurance percentages shown in the above chart represent what the member is responsible for paying.

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Vision

We are proud to offer you a vision plan.

The EyeMed vision plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the EyeMed network.

Following is a high-level overview of the coverage available.

Key Vision Benefits	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 Copay	Up to $40
Lenses (once every 12 months)		
Single Vision	$25 Copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $70
Frames (once every 12 months)	$150 allowance; $20% off balance over $150	Up to $105
Contact Lenses (once every 12 months; in lieu of glasses)	$150 allowance; $15% off balance over $150	Up to $150

Flexible Spending Accounts

We provide you with an opportunity to participate in up to two different flexible spending accounts (FSAs) administered through Payflex. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

For 2023, you may contribute up to $3,050 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions
- Dental treatment
- Orthodontia
- Eye exams/eyeglasses
- Lasik eye surgery
- Menstrual Care Products

Limited-Purpose Health Care FSA (for HSA participants)

If you enroll in the HSA medical plan, you may only participate in a limited-purpose Health Care FSA. This type of FSA allows you to be reimbursed for eligible dental, orthodontia and vision expenses while preserving your HSA funds for eligible medical expenses.

Dependent Care FSA

For 2023, you may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns). Some qualified expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

FSA Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Unused funds will **NOT** be returned to you or carried over to the following year.

You can incur expenses for 2.5 months after the end of the plan year.

Maximum contribution amount is established by the IRS and your employer each year. See plan document for details.

Voluntary Life and AD&D

Life/AD&D Insurance

Life Insurance provides your named beneficiary(ies) with a benefit of one times your base annual salary ($25,000 minimum and $250,000 maximum) n the event of your death.

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). In the event that your death occurs due to a covered accident, both the Life and the AD&D benefit would be payable.

Voluntary Life/AD&D (Employee-paid)

You may purchase coverage through UNUM for yourself and your eligible family members.

Benefit Option		Guaranteed Issue[1]
Employee	$10,000 increments; minimum of $10,000 up to $500,000	$200,000
Spouse/RDP	$5,000 increments; minimum of $5,000 up to $500,000 (not to exceed 100% of your additional life coverage)	$30,000
Child(ren)	$2,000 increments; minimum $2,000 up to $10,000	$10,000

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

Disability

Disability insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness.

Short-Term Disability	
Provided at NO COST to you through UNUM	
Benefit Percentage	60%
Weekly Benefit Maximum	$1,500
When Benefits Begin	After 14th day of disability
Maximum Benefit Duration	24 weeks
Long-Term Disability	
Provided at NO COST to you through UNUM	
Benefit Percentage	66 2/3%
Monthly Benefit Maximum	$8,000
When Benefits Begin	After 180th day of disability
Maximum Benefit Duration	Social Security Retirement Age

Employee Assistance Program (EAP)

Life is full of challenges, and sometimes balancing it is difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The employee assistance program (EAP) is provided at NO COST to you through UNUM

The EAP can help with the following issues, among others:

- Mental Health
- Relationship or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal or financial

EAP Benefits

- Assistance for you and your household members
- Unlimited toll-free phone access and online resources

Travel Assistance Program

The travel assistance program through Unum can assist with many unexpected travel emergencies within the U.S. and abroad. Examples include replacing lost prescriptions and passports, medically necessary repatriation, emergency cash coordination, interpreter/translator services, and more. The Travel Assistance Program is offered through Unum. Please contact HR for additional details.

Voluntary Benefits

Our benefit plans are here to help you and your family live well—and stay well. But did you know that you can strengthen your coverage even further? It's true! Our voluntary benefits through Voya are designed to complement your health care coverage and allow you to customize our benefits to you and your family's needs. The best part? Benefits from these plans are paid directly to you! Coverage is also available for your spouse and dependents. You can enroll in these plans during Open Enrollment—they're completely voluntary, which means you are responsible for paying for coverage at affordable group rates.

Accident Insurance

Accident insurance can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: You visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But in reality, treating a broken leg can cost up to $7,500[1]. And it's not only broken limbs – an average non-fatal injury could cost you $6,620 in medical bills[2]. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Critical Illness

Most of us don't have an extra $7,000 ready to spend – even if we do, we don't want to use it all on medical expenses. Unfortunately, the average cost to treat a critical illness is just that: $7,000[3]. But with critical illness insurance, you'll receive a lump-sum benefit if you are diagnosed with a covered condition that you can use however you would like, including to help pay for: treatment (e.g. experimental), prescriptions, travel, increased living expenses and more.

Hospital Indemnity Insurance

When your loved one needs to be hospitalized, your family deserves to focus on their wellbeing–not the stress of the average three-day hospital stay, which can cost you $30,000[1]. Hospital indemnity insurance can help reduce costs by paying you or a covered dependent a benefit to help cover your deductible, coinsurance and other out-of-pocket costs due to a covered sickness or injury related hospitalization.

Long Term Care

You have the option of purchasing LTC insurance, which refers to a variety of services designed to help you perform the functions of day-to-day living to help you remain as independent as possible. Some LTC services provide assistance with day-to-day activities for people with a chronic illness or cognitive impairment, such as dementia. Others follow a period of rehabilitation for people who continue to require assistance to perform daily activities. Because neither medical insurance nor Medicare are primarily designed to pay for these services, LTC can help provide a way for you to pay for this care. It can help you retain assets and income set aside for retirement, as well as remain independent by providing the money to allow you to decide where and how your care will be provided.

1. *Why health insurance is important: Protection from high medical costs. HealthCare.gov*
2. *Average medical cost of fatal and non-fatal injuries by type in the USA, December 2019. National Library of Medicine.*
3. *MetLife Accident and Critical Illness Impact Study.*

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	Leading Edge	888-643-1434	www.leadingedge.wealthcareportal.com
Dental	Delta Dental of Ohio	800-524-0149	www.deltadentaloh.com
Vision	EyeMed	866-939-3633	www.eyemed.com
Flexible Spending Accounts (FSAs)	Custom Design Benefits	800-598-2929	www.customdesignbenefits.com
Life/AD&D	UNUM	800-445-0402	www.unum.com
Disability	UNUM	Contact HR	www.unum.com
Employee Assistance Program (EAP)	UNUM	800-854-1446	unum.com/employees/services/life-balance
Voluntary Benefits	Voya	877-236-7564	https://presents.voya.com/EBRC/capitaluniversity

Benefits Website:

Our benefits website **https://benefits.plansource.com** can be accessed anytime you want additional information on our benefits program.

Questions?

If you have additional questions, you may also contact:

Tammy Scott, Hub International
800.558.5658 x 2682
tammy.scott@hubinternational.com

Molly Kelley, Claims Advisor Hub International
800.558.5658 x 2684
molly.kelley@hubinternational.com

HUB

2023 Rates

Medical/Rx Rates

PPO Plan			
	Employee Biweekly	Employee Semi-Monthly	Capital Monthly
Employee	$88.24	$95.59	$806.64
Employee & Spouse	$258.55	$280.10	$1,435.44
Employee & Child(ren)	$204.26	$221.28	$1,133.99
Family	$333.53	$361.33	$1,851.70
HDP Plan			
	Employee Biweekly	Employee Semi-Monthly	Capital Monthly
Employee	$18.90	$20.48	$852.58
Employee & Spouse	$100.80	$109.20	$1,568.66
Employee & Child(ren)	$79.80	$86.45	$1,264.48
Family	$129.79	$140.61	$1,988.72

2023 Rates and Annual Plan Maximums

Dental Rates

Delta Premier			
	Employee Biweekly	Employee Semi-Monthly	Capital Monthly
Employee	$2.71	$2.94	$26.10
Employee & Spouse	$7.62	$8.25	$42.53
Employee & Child(ren)	$9.84	$10.66	$54.94
Family	$14.85	$16.09	$82.90

Vision Rates

EyeMed			
	Employee Biweekly	Employee Semi-Monthly	Capital Monthly
Employee	$3.30	$3.58	$0.00
Employee & Spouse	$6.28	$6.81	$0.00
Employee & Child(ren)	$6.61	$7.16	$0.00
Family	$9.72	$10.53	$0.00

Health Savings Account (HSA)

Plan Maximum	
Single Coverage	$3850
Family Coverage	$7,750
Age 55 +	Additional $1,000

Flexible Spending Account (FSA)

Plan Maximum	
Healthcare	$3,050
Dependent Care	$5,000

Retirement 403(b)

Plan Maximum	
General Election	$22,500
Age 50 +	Additional $7,500

For those with 15 or more years of service there may be the opportunity to contribute an additional $3,000. Please see the Human Resources Office for more details.

Reminder!

Capital contributions to your HSA. Capital will contribute $1000/$2000 for those enrolled in the HDP.

Note

Capital University will not monitor whether or not contributions exceed the legal maximums. You, the participant, are responsible for ensuring that your contributions stay within allowed limits and, if they exceed those limits, you must take the appropriate actions.

Free Calm Subscription Provided by Capital University!

Millions of people are experiencing lower stress, less anxiety, improved focus and more restful sleep with Calm. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.

To unlock your free Calm subscription, visit: **https://www.calm.com/b2b/capital-university/subscribe**

This must be done on a web or mobile browser (not in the app itself).

Steps to Create an Account

1. Create an account or sign in to your existing Calm account.
2. Enter your work email in the box provided to activate the subscription on your Calm account.
3. Download the Calm app. And log in to your account to access the premium content.

Retirement

Capital University's 403(b) plan makes saving for retirement easy and painless. Employees who join Capital University on or after January 1, 2023, will be eligible for 2.5% employer contribution subject to a 5 year vesting schedule into a 403(b) plan with TIAA. After 5 years of employment with Capital, the University's contribution rate goes to the employer maximum contribution rate and the employee becomes fully vested. Eligible employees that were hired before January 1, 2020, receive the maximum University contribution rate which is currently set at 4.5% of your base wage. All employee contributions have immediate vesting. You may contribute additional dollars via payroll deduction up to the federal maximum beginning on your start date, although this is not required in order to receive the employer contributions. Employees hired on or after January 1, 2023 are subject to an auto-enroll of 2.5% unless they elect differently. Capital reserves the right to make changes to the plan as needed at any time. Learn more about your investment choices online at **TIAA.org/capital.**

Paid Time Off and Additional Benefits

There are additional benefits that come from working in a university setting as well as working in a caring community. This summary highlights these benefits and the options that are available to employees working at least half-time. For more detailed information, please contact human resources at **614.236.6168** or **benefits@capital.edu**.

Vacation Leave

Nonexempt and Exempt staff

20 days per year

Maximum account balance = 25 days

Faculty and exempt staff working less than 12 months

Employees in this category follow the academic calendar year and do not accrue vacation leave.

Sick Leave

Exempt administrators and faculty

20 days per year

Maximum account balance = 6 months

Nonexempt staff

22 days per year

Maximum account balance = 6 months

3 days per year can be used as personal days

Paid Holidays

Capital observes the following holidays:

- Good Friday
- Memorial Day
- Juneteenth
- Fourth of July
- Labor Day
- Wednesday before Thanksgiving
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Week (including Christmas Eve through New Year's Day)

Funeral Leave

Up to five days paid leave for immediate family members—spouse/ domestic partner, child or step-child, mother, father. Up to three days paid leave for other family members—brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, grandmother, or grandfather.

Tuition Benefits

Employees, their spouses and dependent children are eligible for tuition remission for undergraduate programs at Capital University. Full-time undergraduate students are required to complete a Free Application for Federal Student Aid (FAFSA). Employees may also participate in graduate-level programs if they are job related.

Eligible employees may apply for Tuition Exchange which allows their dependent children to attend a participating school for a discounted tuition.

Discounted Meals

Capital University's dining services are offered on campus through Aladdin. They offer discounted meal rates at the Main Dining Room (MDR, located on the second floor of the Student Union) for faculty and staff. You can also load CapBucks on your ID badge by visiting the Aladdin office (located in the MDR) or by phone **614.236.6125**.

Community Benefits

Below are some of the added benefits that are available to employees of the University, including special offers and discounts. To take advantage of these offers, identify yourself as a Capital University employee. You may also be required to show your Capital University ID card.

- Athletic events
- Capital Center
- Library
- Schumacher Gallery
- Music concerts
- Parking privileges
- Bookstore discounts
- Conference services discounts
- Restaurant discounts
- Theater productions

Glossary of Terms

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment – The flat fee that you pay towards the cost of covered medical expenses.

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out of pocket. Under some plans, the deductible is waived for certain services.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

In-Network – Care received from an outlined list of health care practitioners.

Indemnity – Benefit that pays a fixed dollar amount for a particular service.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, other health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicaid – An insurance program jointly funded by the state and federal governments and managed by the states to provide health coverage to those under age 65.

Medicare – An insurance program administered by the U.S. government to provide health coverage to those typically age 65 and older.

Member – You and your covered dependents when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-Network – Care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-Pocket Expenses – Amount that you must pay towards the cost of healthcare services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OPM) – The top amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply. Under some plans, the deductible and OPM may have the same dollar limit.

Preferred Provider Organization (PPO) – A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium – The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP) – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in similar geographic area, and (3) reasonable in light of any unusual clinical circumstances, etc.

Special Enrollment Notice

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer.

Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact: Human Resources

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee.

Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage and when is it available?

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

Paperwork Reduction Act Statement

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

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

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

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [see medical plan summary above]. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with child birth. In general, insurers may not:

- Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- Require that a provider obtain authorization from the insurer for prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the benefit material for the plan in which you are enrolled.

ERISA Compliance

Some or all of the plans described in this booklet are subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and other pertinent legislation. ERISA regulations require that plan participants be furnished periodically with descriptions of benefit plans and that they are notified of any material modifications in such plans.

The descriptions of benefits presented in this booklet are intended to summarize current plans. Certificate of Coverages and/or insurance certificates are provided separately to participants in each of the benefit plans as appropriate. To the extent any of the information contained in this booklet is inconsistent with the terms of the official descriptions or actual benefit plans, the terms of the latter descriptions or plans shall govern. Although we intend to continue benefits indefinitely, modification or cancellation of any of these plans is at our discretion.

LEADING EDGE ADMINISTRATORS

4631 WOODLAND CORPORATE BLVD STE 310
TAMPA, FL 33614-2441

[DR-]

Important Plan Document Information - Do Not Discard!

FORWARDING SERVICE REQUESTED

J056 1

JOHN SAMPLE
100 SAMPLE STREET
APT S
SAMPLEVILLE SM 11111

NOTICE:

Identification Cards Enclosed

IMPORTANT INFORMATION ABOUT YOUR 2023 MEDICAL BENEFIT PLAN

Welcome to your new 2023 Medical Benefit Plan!

This welcome package contains your member identification cards, contact information and summary of benefit coverage about your new 2023 medical plan.

Your benefits contain:
Medical Benefits via the **National PPO (BlueCard PPO) network** providing you access to over **700,000** medical providers and **4,500** hospitals nationwide.

The attached Summary of Benefits and Coverage (SBC) contains a listing of covered services and your out-of-pocket responsibilities.

To find a **BlueCard** network provider, please visit **www.empireblue.com**

Valenz Concierge:
Valenz NavCare navigators are available Monday through Friday from 7AM to 8PM (EDT). Their phone number is **877-208-5952**

You may access valuable information 24/7 about your plan and claims through Leading Edge's MESA member website: **https://mesa.leadingedgeadmin.com**. The Leading Edge member website will provide you with self-service tools to help in your review of eligibility, claim payments, plan documents, print ID cards and other services.

All new users of the Leading Edge member website must register online prior to accessing their claim and benefit information.

Still have questions?
Don't forget to contact Valenz NavCare's dedicated navigators at **877-208-5952.**

Thank you
Leading Edge Administrators

BlueCard® PPO Program

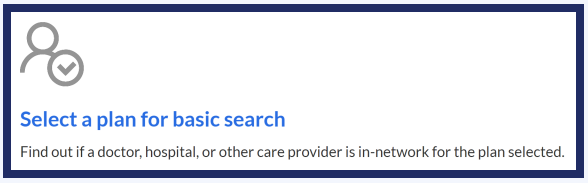
Empire BlueCross BlueShield
An Anthem Company your Whole Health Partner

Need to find a doctor?

Take your benefits with you and choose with confidence using the Find Care tool

1 Go to **empireblue.com/find-care**
or
select the **Find Care** button on the top-right of the **empireblue.com** homepage.

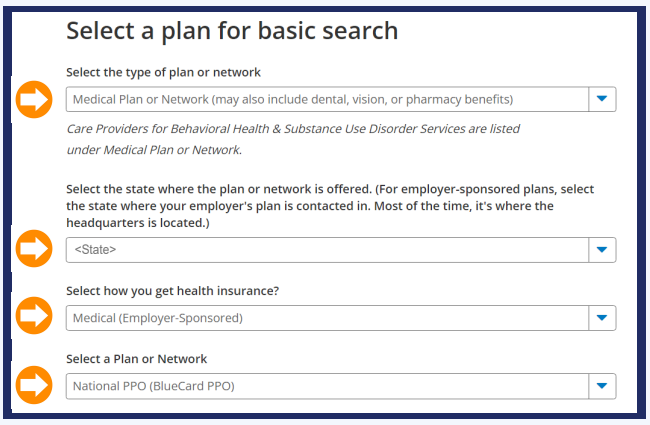
2 On the next screen, choose **Select a plan for basic search**.



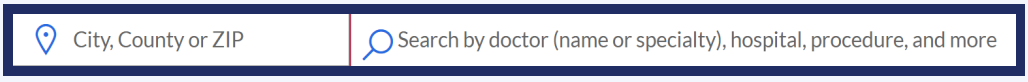
3 Next, you will select:

- **Medical Plan or Network**
- **The state you would like to find care**
- **Medical (Employer-Sponsored)**
- **National PPO (BlueCard PPO)**

Click **Continue**.



4 Use the search bar to narrow your search for an in-network provider.



Savings Plus Plan (SPP) Frequently Asked Questions

What is the Savings Plus Plan (SPP)?
The Savings Plus Plan is a program developed to minimize members out of pocket expenses through competitive pricing negotiation. This focused health benefit payment program applies to all inpatient and outpatient facility services as well as a limited number of surgical and medical services. These SPP services are identified in your plan booklet. Under the SPP, the provider's reimbursement level for these services will be a percentage of Medicare.

Do I have a provider network as part of my SPP?
Yes, this program will use the Blue Card PPO network.

What services are subject to SPP?
Below are examples of services that will fall under SPP:

- all inpatient and outpatient facility services
- certain high dollar in-patient and out-patient surgeries
- high-cost imaging such as MRI and PET Scans
- Substance Abuse services
- Dialysis

You should always refer to your Summary Plan Description (plan booklet) for a comprehensive list of SPP services.

Who should I call if I have any questions about my Savings Plus Plan? (Including bills from providers on Savings Plus Plan services)

Should you have any questions about access to care or a medical bill, please contact the Valenz NavCare team at (877) 208-5952.

Both Valenz NavCare and Leading Edge Administrators will have dedicated team members to help you with any questions or concerns.

Will I need to get preauthorization for some services?
Yes, certain services will require preauthorization by your provider. Failing to preauthorize identified services may increase your out-of-pocket portion of payment. Please refer to your Summary Plan Description for a comprehensive list of which services require preauthorization.

How do I obtain a preauthorization?
Your doctor is responsible for preauthorization. He/she should call the phone number on your ID card to confirm that you have coverage, and determine if the service being provided requires preauthorization.

I had a procedure done and I received a letter in the mail saying my claim is denied pending medical notes. What does that mean? Who is responsible to obtain this?

Medical notes are required for procedures done in an inpatient setting to confirm that the services rendered were for medical necessity. Members should follow up with their doctor or hospital to submit medical documentation for review.

I recently went to the doctor and had lab work done. I'm getting a bill in the mail saying I owe for lab work services. What do I do?

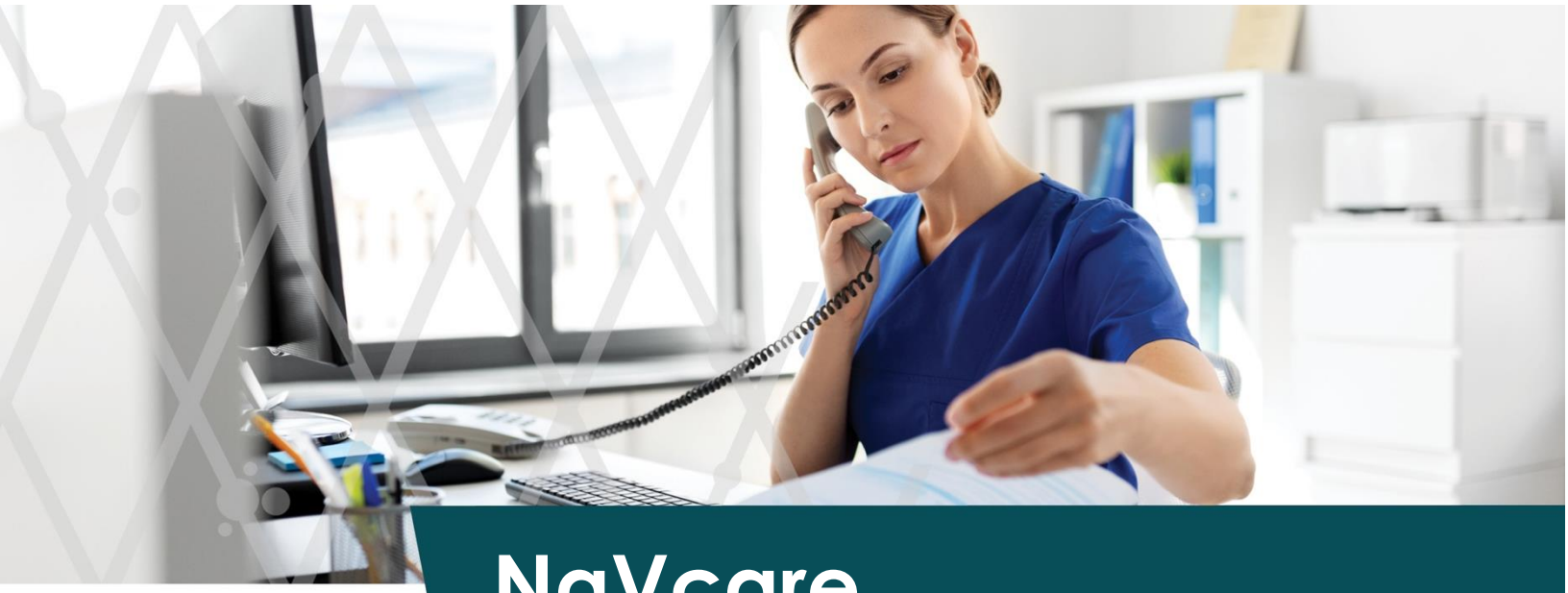
You should always make sure you review your EOB (Explanation of Benefits) when reviewing a bill from your provider. Should you have any questions about a medical bill, please contact the Valenz NavCare team at (877) 208-5952.

Both Valenz NavCare and Leading Edge Administrators will have dedicated team members to help you with any questions or concerns.

LEADING EDGE ADMINISTRATORS

Vālenz® CARE

(877) 208.5952
valenzhealth.com



NaVcare

Personalized guidance throughout the member journey

Do you have a question about your health plan, your care coordination, your provider or your bill? With Vālenz®, you have access to a dedicated Navigator who has deep expertise in your coverage and benefits. NaVcare enhances the member experience and helps chart your path to smarter, better, faster healthcare. You're just one phone call away from answers to your questions:

1. How do I choose a high-quality doctor?
2. Which hospitals are in my network?
3. How do I reduce my out-of-pocket costs?
4. Who can help me understand my medical bill or my Explanation of Benefits?
5. What should I do if I need help paying my bill?
6. Who can advocate on my behalf with my insurance company?

Contact your **NaVcare** navigator

877-208-5952