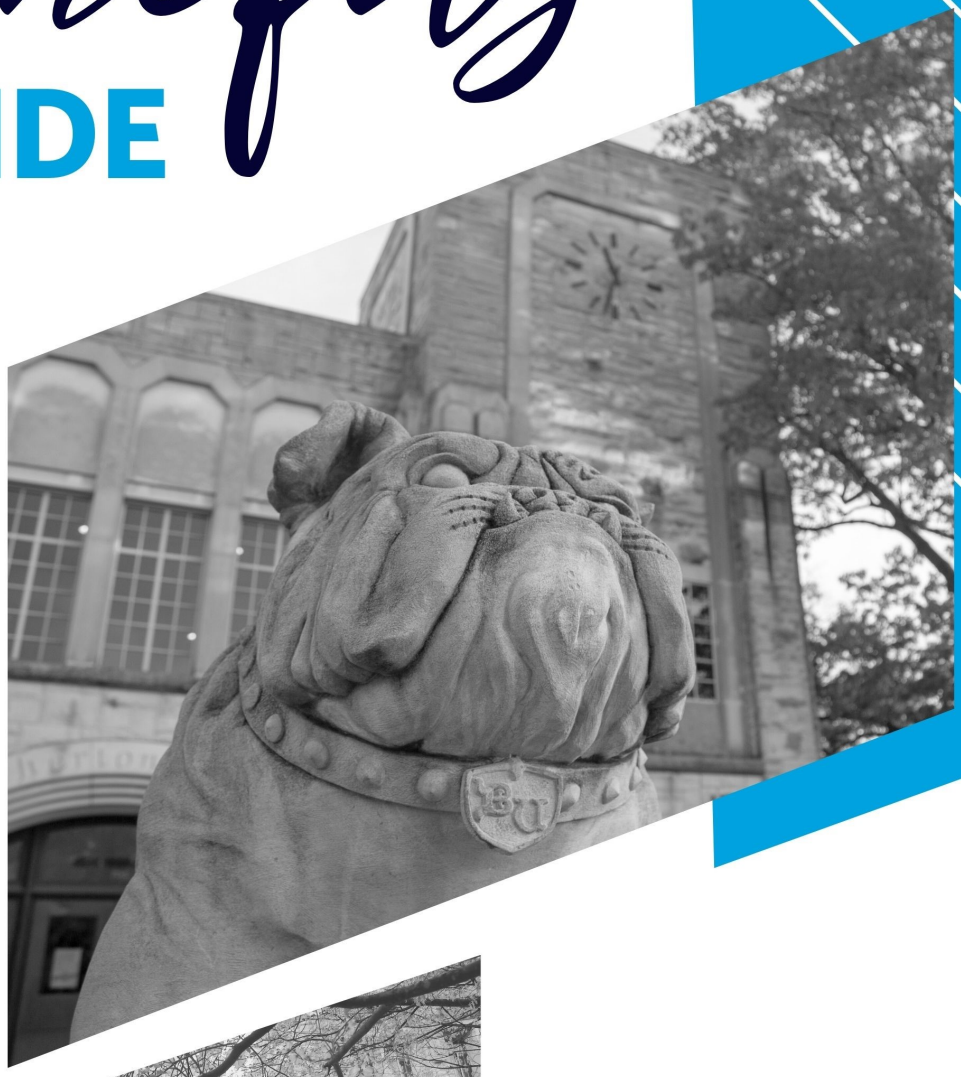
Benefits GUIDE



BUTLER

2025

benefits

DESIGNED FOR YOU

At Butler University, the health and well-being of our employees and their families is our top priority. This is why we offer a comprehensive benefits package that provides healthcare coverage, financial protection and more.

Understanding your benefits and knowing how to use them is just as important as having access to them. Review this benefits guide to learn about the benefits available to you for the 2025 plan year.

This booklet is intended as a high level overview and is for informational purposes only. The plan documents, contribution schedules, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

IMPORTANT CONTACTS

Questions About	Carrier Name	Phone	Website/Email
Medical	Anthem	See ID Card	www.anthem.com
Prescription Drugs	Prime Therapeutics	(800) 424-0472	www.primetherapeutics.com
Specialty Drug Program	PaydHealth	(877) 869-7772	
Dental	Delta Dental	(800) 524-0149	www.memberportal.com
Vision	EyeMed	(866) 939-3633	www.eyemed.com
Flexible Spending Account	WEX	(866) 451-3399	https://www.wexinc.com/solutions/benefits/participants-employees
Health Savings Account	UMB	(866) 520-4HSA	hsa.umb.com Employer Code: THA0001-143674
Basic Life and AD&D	OneAmerica	(800) 553-5318	www.oneamerica.com
Voluntary Life/AD&D	OneAmerica	(800) 553-3522	www.oneamerica.com
Short-Term Disability	OneAmerica	(800) 553-5318	www.oneamerica.com
Long-Term Disability	OneAmerica	(800) 553-5318	www.oneamerica.com
Telemedicine	LiveHealth Online	Available through the Sydney Health mobile app	
Employee Assistance Program	OneAmerica	(855) 365-4754	www.guidanceresources.com Company Web ID: ONEAMERICA6
403b (Retirement)	TIAA	(800) 842-2252	TIAA.org/butler
Benefits Central Advocacy	Hylant	(833) 856-0111	BUadvocate@hylant.com
Human Resources • HR Benefits & Wellness Office JH 055	Butler	(317) 940-9355	benefits@butler.edu – confidential information & documents

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 39 for more details.

BENEFITS ELIGIBILITY

Butler University offers health and welfare programs to eligible full-time employees.

As a new employee, you may enroll in benefits during the first 30 days of employment. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Benefits Effective: First day of employment

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans as described below.

Benefits	Legal Spouse	Dependent Children*
Medical / Rx	☑	☑
Dental	☑	☑
Vision	☑	☑

* All dependent child coverage terminates at the end of the month they reach age 26

You may be asked to provide proof of dependent eligibility, such as a copy of a certified marriage certificate registered to county/state, birth certificate or court documents.

CHANGING YOUR BENEFITS

Due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment.

The only exception is if you experience a qualifying life event. Election changes must be consistent with your life event and requested **within 30 days** of the qualifying life event. Qualifying events include, but are not limited to:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Death of a dependent
- Change in your spouse's employment status
- Change in coverage under your spouse's plan
- A loss of eligibility for other health coverage
- Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)
- Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP

COBRA CONTINUATION COVERAGE

When you or any of your dependents no longer meet the eligibility requirements for your health plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

ENROLLING IN BENEFITS

ACTION ALERT

Choose your benefits wisely! After the enrollment deadline, benefit elections cannot be changed or canceled until the next enrollment period unless you have a qualifying event.

OPEN ENROLLMENT

Each fall, Butler University holds annual open enrollment, which provides you the opportunity to enroll, waive or change benefit elections without experiencing a qualifying life event.

GETTING STARTED: EVALUATE

When reviewing your benefit options there are things you should consider including:

- Your expected total annual healthcare cost, which includes:
  - Your premium contributions (what you pay for benefits)
  - Your expected out-of-pocket costs such as deductibles, coinsurance and copays.
- Healthcare plan features that are important to you and how you prefer to pay for coverage

Use the websites and phone numbers in the *Important Contacts* section to see which doctors and other healthcare providers you can use under your plan choices. If you have dependents that live out of state, check on provisions for coverage of members away from home.

HOW TO ENROLL: MAKING YOUR ELECTIONS

WHO PAYS

Butler University pays 100% of some benefits; other benefit offerings require your contribution.

Benefit	You Pay	Butler University Pays
Medical and Prescription Insurance	X	X
LiveHealth Online (Telemedicine)	X	X
Dental Insurance	X	X
Vision Insurance	X	X
Health Savings Account	X	X
Flexible Spending Accounts	X	
Short-Term Disability Insurance		X
Long-Term Disability Insurance		X
Basic Life and A&D Insurance		X
Voluntary Life and AD&D Insurance	X	
Employee Assistance Program		X
Retirement	X	X

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with "before-tax" dollars (e.g., medical, dental and vision coverage). By paying premiums with "before-tax" dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you have to notify benefits@butler.edu if you intend to make a change.

Employee - COST OF COVERAGE SUMMARY

WHAT YOU PAY

	Bi-Weekly Calendar Year (12 months)	Monthly Calendar Year (12 months)	Bi-Weekly Academic Year (10 months)	Monthly Academic Year (10 months)
Medical				
PPO Plus Plan				
Employee	$101.81	$220.59	$132.35	$264.70
Employee + Spouse	$328.34	$711.41	$426.85	$853.69
Employee + Child(ren)	$201.61	$436.82	$262.09	$524.18
Employee + Family	$444.11	$962.24	$577.35	$1,154.69
PPO Core Plan				
Employee	$32.85	$71.18	$42.71	$85.42
Employee + Spouse	$165.45	$358.47	$215.08	$430.16
Employee + Child(ren)	$101.22	$219.30	$131.58	$263.16
Employee + Family	$252.90	$547.95	$328.77	$657.54
HDHP-HSA Plan				
Employee	$24.40	$52.86	$31.71	$63.43
Employee + Spouse	$132.64	$287.39	$172.44	$344.87
Employee + Child(ren)	$80.58	$174.59	$104.75	$209.51
Employee + Family	$202.85	$439.52	$263.71	$527.42
Dental ★				
Employee	$3.42	$7.41	$4.45	$8.89
Employee + Spouse	$13.03	$28.24	$16.94	$33.89
Employee + Child(ren)	$7.87	$17.05	$10.23	$20.46
Employee + Family	$17.14	$37.14	$22.28	$44.57
Vision ★				
Employee	$3.80	$8.23	$4.94	$9.88
Employee + Spouse	$6.80	$14.74	$8.84	$17.69
Employee + Child(ren)	$7.95	$17.22	$10.33	$20.66
Employee + Family	$9.84	$21.32	$12.79	$25.58

★ Pleased to announce NO increase to Dental or Vision contributions for 2025

BENEFITS CENTRAL ADVOCACY PROGRAM

Navigating the healthcare system is challenging. If you need help, you can contact the Benefits Central Advocacy Line for one-on-one help from an industry expert!

IF YOU EVER HAVE QUESTIONS ABOUT THE FOLLOWING TOPICS*, THE BENEFITS CENTRAL ADVOCACY LINE IS HERE TO HELP

BILLING

PRESCRIPTION COVERAGE

CLAIMS

GENERAL BENEFIT QUESTIONS

ELIGIBILITY

ID CARDS

An advocate can urge insurance companies to get tasks done, provide justifications when filing an appeal, write proposals for negotiating a payment plan for medical bills and more!*

**For other HR related questions, please email benefits@butler.edu.*

HOW TO CONTACT BENEFITS CENTRAL ADVOCACY LINE

CALL: Talk to an advocate directly at: **(833) 856-0111**

TEXT: Send a message with your name and call back number to **317-266-9392**
(Standard messaging and data rates apply)

EMAIL: Send a description of your insurance issue to **BUadvocate@hylant.com**.
(Include your name and phone number)

HOURS: Monday - Friday 8:30 a.m.-5:00 p.m. (EST)
(An advocate will reach out to you within 24 business hours)

MEDICAL BENEFITS OVERVIEW

Butler University offers three medical plan options, which are administered by Anthem.

- 2 PPO medical plan options
- 1 High-deductible health plan (HDHP) option

PPO VS. HDHP

PPO

- Higher cost per paycheck
- Lower embedded deductibles
- You can fund a healthcare Flexible Spending Account (FSA)

HDHP

- Lower cost per paycheck
- Higher embedded deductible
- You and Butler can fund a Health Savings Account (HSA)

THREE THINGS TO CONSIDER

1. What **PLANNED** medical services do you expect this upcoming year (i.e., birth of a child, surgery, etc.)
2. Do you prefer to pay **MORE** per paycheck with a lower deductible and out-of-pocket cost, or **LESS** per paycheck with a higher deductible and out-of-pocket cost, but you have the ability to offset those costs with an HSA.
3. Do you or any of your covered dependents take routine prescription **MEDICATIONS** on a regular basis? PPO members are only required to pay the copay amount. HDHP members must first meet their deductible before the coinsurance amount applies.

EVALUATE WHICH PLAN IS BEST FOR YOU

Take advantage of UMB's Plan Calculator to compare the HDHP to the PPO Plans. Enter in the plan details and your expected plan utilization to determine which option is the most advantageous and best meets your individual needs.

Scan QR code for UMB Calculator Tool

DEDUCTIBLE

The amount you must pay for services before the medical plan begins to pay.

COPAY

The fixed amount you pay at the time of service at a providers office or pharmacy.

OUT-OF-POCKET (OOP) MAX

The maximum amount of money you will pay for medical services during the plan year. The OOP max is the sum of your copays, deductible and coinsurance payments.

COINSURANCE

A form of cost-sharing where you and the insurance plan share expenses in a specified ratio after you meet your deductible (until you reach your OOP max).

MEDICAL BENEFITS OVERVIEW

★ Enhancement for 2025

The following is a summary of your medical benefits provided by Anthem. You will pay less out of your pocket when you choose a provider within the Blue Access PPO network. You may access a list of participating providers by visiting www.anthem.com. For a more detailed explanation of benefits, please refer to your certificate of coverage or SBC.

Anthem

	PPO Plus Plan		PPO Core Plan		HDHP-HSA Plan	
	In-Network *What You Pay*	**Out-of-Network** *What You Pay*	**In-Network** *What You Pay*	**Out-of-Network** *What You Pay*	**In-Network** *What You Pay*	**Out-of-Network** *What You Pay*
Look for a participating provider in the following network: **Blue Access PPO**						
DEDUCTIBLES						
Individual	$1,150	$2,300	$1,650	$3,300	$3,300	$6,400
Family	$2,300	$4,600	$3,300	$6,600	$6,600	$12,800
COINSURANCE						
Plan Pays	80%	50%	75%	50%	80%	60%
You Pay	20%	50%	25%	50%	20%	40%
OUT-OF-POCKET MAXIMUM						
Individual	$3,450	$6,900	$4,950	$9,900	$5,600	$11,200
Family	$5,460	$10,920	$8,460	$16,920	$9,400	$18,800
COMMONLY USED SERVICES						
Physician Visit	$20 Copay	50% After Deductible	$30 Copay	50% After Deductible	20% After Deductible	40% After Deductible
Specialist Visit	$40 Copay	50% After Deductible	$50 Copay	50% After Deductible	20% After Deductible	40% After Deductible
Preventive Care	No Charge	50% After Deductible	No Charge	50% After Deductible	No Charge	40% After Deductible
LiveHealth Online *Primary Care/Mental Health/Substance Abuse* *Specialist*	$0 Copay $40 Copay	N/A	$0 Copay $50 Copay	N/A	0% After Deductible 20% After Deductible	N/A
Urgent Care Visit	$75 Copay	50% After Deductible	$75 Copay	50% After Deductible	20% After Deductible	40% After Deductible
Emergency Room *Facility* *Doctor/Other Services*	$200 Copay		$200 Copay		20% After Deductible 20% After Deductible	
Diagnostic Services* *(Labs, X-Ray, Imaging)*	20% After Deductible	50% After Deductible	25% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Hospitalization	20% After Deductible	50% After Deductible	25% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
★ **PRESCRIPTION DRUGS - 90-Day Supply available through retail or home delivery**						
Deductible	*N/A*		*N/A*		*Medical Deductible Must Be Met Before Amount Below Takes Effect*	
Tier 1	$10 / $10		$10 / $20		20% Coinsurance	
Tier 2	$35 / $60		$35 / $70		20% Coinsurance	
Tier 3	$75 / $150		$75 / $150		20% Coinsurance	
Tier 4	25% Up To $150 Max / Not Covered		25% Up To $150 Max / Not Covered		20% Coinsurance / Not Covered	

**Diagnostic services are no charge when receiving services in a doctor's office.*

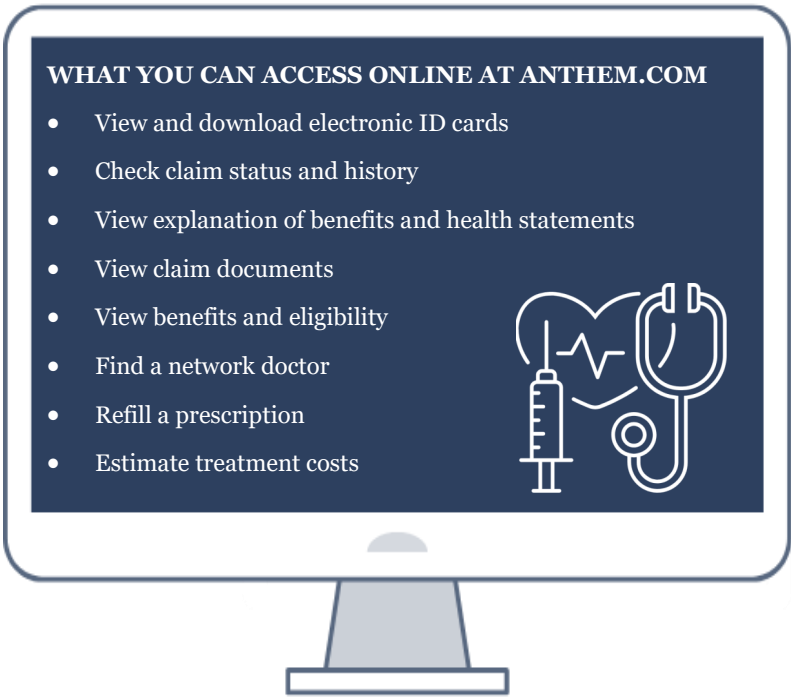
See Summary Plan Document for additional details. You may also contact the plan administrator with questions regarding benefits.

ANTHEM MEMBER TOOLS

Anthem provides online resources to help you make well-informed choices for care and make best use of your health care dollars. Our easy, handy tools let you find a new doctor, compare health care costs and more.

CREATE YOUR ANTHEM MEMBER ACCOUNT

- Visit anthem.com and click **Log In**
- Scroll down and click **Register Now**
- Click **Member ID**
- Enter your Member ID and Group Number (found on the front of your medical ID card), first name, last name, date of birth and click **Next**
- Follow the remaining prompts to create your Anthem member account



SYDNEY HEALTH MOBILE APP

Access your benefits on the go with the Sydney Health mobile app. You may access all the same tools through the app as you can online, including virtual visits through LiveHealth Online.

Click the link to your respective app store to download the Sydney Health mobile app

GET IT ON Google Play

Download on the App Store

EASILY ACCESS VIRTUAL CARE THROUGH LIVE HEALTH ONLINE DIRECTLY WITHIN THE SYDNEY HEALTH APP.

TELEMEDICINE OVERVIEW

We understand it may not always be convenient to go to the doctor, which is why we offer you the opportunity to video chat with a doctor for non-emergency situations. **LiveHealth Online (LHO) gives you 24/7/365 access to a doctor** through the convenience of phone or video consults. It's an affordable option for quality medical care.

Telemedicine services through **Anthem's LiveHealth Online** provide you, your spouse and eligible dependents on-demand phone, video and email access to US based licensed physicians. You can connect with a network of physicians for information, advice and treatment including prescription medication when appropriate.

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone or online video
- Prompt treatment
- A network of US based, licensed doctors that can treat children at any age
- No limit on consults, so take your time
- Secure, personal and portable electronic health record

Conditions Treated Through LiveHealth Online

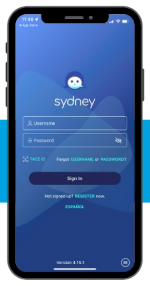
- Cold and Flu
- Sinus Conditions
- Pink Eye
- Allergies
- Upset Stomach
- Urinary Tract Infections
- Mental Health
- Substance Abuse
- Specialty Care

When Can I Use LiveHealth Online?

- Your Primary Care Physician is unavailable
- Need treatment for a medical condition
- On a vacation or a business trip
- After business hours or on a weekend
- When you need non-emergent care now
- Any time at home or away
- Request prescription
- Need a short-term prescription refill

COST OF CARE	PPO Plan	PPO Core Plan	HDHP-HSA Plan
Primary Care/Mental Health/Substance Abuse	$0 Copay	$0 Copay	0% After Deductible
Specialist	$40 Copay	$50 Copay	20% After Deductible

ACCESS LIVE HEALTH ONLINE THROUGH THE SYDNEY HEALTH MOBILE HEALTH APP!



RIGHT **CARE.** RIGHT **PLACE.** RIGHT **TIME.**

VIRTUAL CARE

<10 Minute Wait Time* | $

When you need non-emergency medical care during the week, in the evenings, or on weekends, ***virtual care through LiveHealth Online may be the place to start.*** You will save time, money, and receive treatment from your mobile device—wherever you are!

- ***Allergies***
- ***Cold/Flu symptoms***
- ***Pink eye***
- ***Sore throat***
- ***Sinus infection***
- ***Rash without fever***

Access LiveHealth Online virtual visits through the Sydney Health mobile app.

PRIMARY CARE PHYSICIAN

<30 Minute Wait Time* | $$

When you need non-emergency medical care that requires hands-on or in-person treatment, your ***primary care physician (PCP) may be the place to start.***

- ***Respiratory infection***
- ***Ear infection***
- ***Depression and/or anxiety***
- ***Sinus pain***
- ***Strep throat***
- ***Diabetic concerns***

Find an in-network PCP by visiting www.anthem.com or through the Sydney Health mobile app.

URGENT CARE

<1 Hour Wait Time* | $$$

When you need minor, but urgent medical care during the week, evenings, or on weekends, ***urgent care may be the place to start.***

- ***Skin rash w/fever***
- ***Sprains & Strains***
- ***Minor burns***
- ***Minor broken bones & fractures (fingers/toes)***
- ***X-rays***
- ***Minor cuts needing stitches***

Find an in-network urgent care facility by visiting www.anthem.com or through the Sydney Health mobile app.

EMERGENCY ROOM

~2 Hour Wait Time* | $$$$

When you need treatment for a medical emergency, visit your nearest ***emergency room or dial 911.***

- ***Slurred speech***
- ***Seizures***
- ***Concussion/Confusion***
- ***Broken bones***
- ***Chest pain or difficulty breathing***
- ***Weakness/numbness on one side***

You can locate an ER near you by visiting www.anthem.com or through the Sydney Health mobile app.

CLEVELAND CLINIC - Complimentary Second Opinion

CONNECTING YOU TO WORLD-CLASS CARE

Receive a complimentary second opinion from Cleveland Clinic specialists

If you are someone with a complex medical condition, you may want to learn as much as possible about your diagnosis and treatment options. Through an exclusive offering for Anthem members, you can now receive a virtual Complimentary Clinical Review from top-ranked specialists at Cleveland Clinic. **This second opinion is available to you at no extra cost.**

Frequently Asked Questions

Why is this program available?
For members to have access to leading experts in specialties such as heart, cancer, gynecology, and urology[1]. That's why Anthem partnered with Cleveland Clinic to provide this Complimentary Clinical Review.

Why Cleveland Clinic?
Cleveland Clinic ranks No. 1 in the nation in cardiology and heart surgery for the 27th year in a row, according to the U.S. News & Report's 2021-2022 review. Cleveland Clinic also ranks No. 2 among U.S. hospitals overall, with more than 3,900 employed physicians to diagnose and treat your condition. The staff is committed to providing the best care for serious and complex medical conditions.

Who is the ideal candidate for a Complimentary Clinical Review?
You are an ideal candidate if you have been diagnosed with a complex condition and would like a second opinion. You will learn about typical treatment plans that may be right for you and find out if Cleveland Clinic can assist with your care.

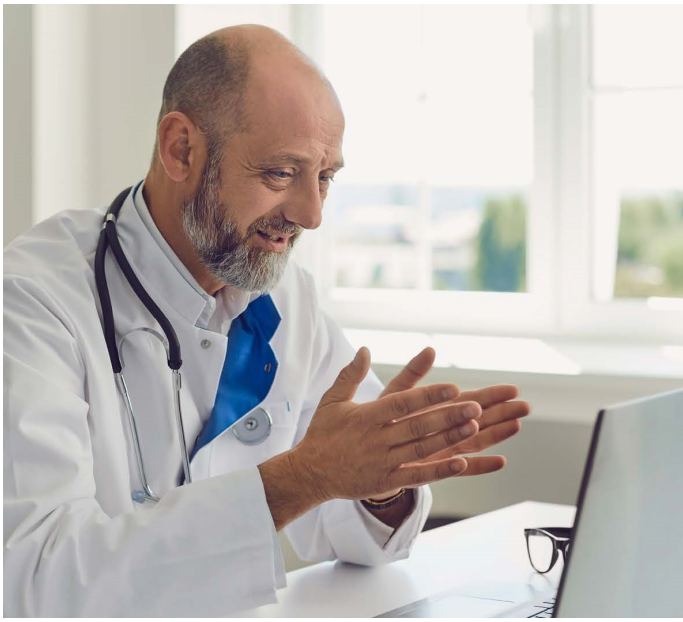
What happens when I schedule a review?
A specialty referral team will answer questions you may have and ask for basic information about your condition. Next, Cleveland Clinic will ensure that the right doctor will review your information and share a typical treatment plan based on your medical condition. The doctor may also talk to you about more advanced treatment options at Cleveland Clinic.

1 Complimentary Clinical Review is available for all healthcare services except primary care, obstetrics, laboratory medicine, radiology, and emergency services.

How long is the wait for a clinical review after I request one?
Cleveland Clinic will work with you to obtain the appropriate information and medical records. You will receive feedback within five business days, by phone or email.

How much does it cost?
The review through Cleveland Clinic is currently offered at no cost to Anthem members. Charges will apply if you choose to schedule follow-up visits.

How do I know if my benefits cover follow-up care?
After your Complimentary Clinical Review, you can choose to schedule an appointment with a Cleveland Clinic specialist. Your Anthem benefits will apply for both virtual and in-person visits. For more information on what services are covered, please contact the Anthem Member Services team at the number provided on your ID card.



What is the difference between a clinical review and a scheduled visit?

Complimentary Clinical Review	Scheduled Visit
Available at no extra cost	Billable visit. Copay will apply.
Receive education about typical treatment options based on your medical information.	Receive a diagnosis for your condition and a treatment plan.
Receive advice and information about alternate or advanced treatment options available at Cleveland Clinic.	Schedule follow-up visits or tests.
Feedback from Cleveland Clinic specialty referral team is provided by phone or email.	Feedback is provided in-person or virtually.

Call or email to request your virtual clinical review at no extra cost.

833-355-0454

anthemreferral@ccf.org

PHARMACY RESOURCES

★ Same administrator as last year, new name

PRIME THERAPEUTICS ★

Prime Therapeutics is your prescription drug administrator. For any pharmacy or prescription drug questions, please contact Prime Therapeutics at (800) 424 - 8274.

PRIME THERAPEUTICS MEMBER PORTAL

To get the most out of your prescription benefits, you must first create a Prime Therapeutics account.

Both you and your enrolled spouse must create a member account.

Prime THERAPEUTICS™ Management

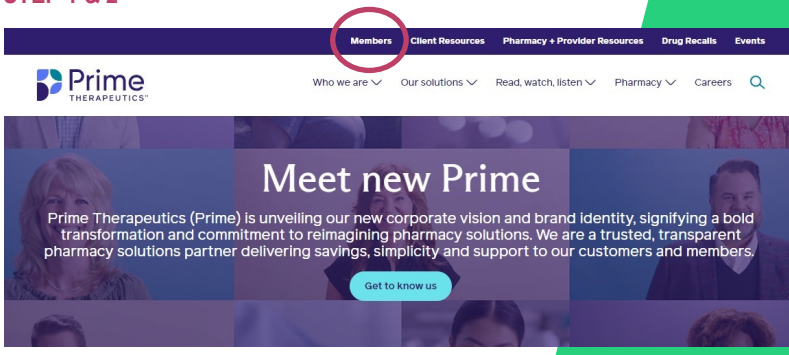
REGISTER FOR A PRIME THERAPEUTICS MEMBER ACCOUNT

STEP 1. Go to **www.primetherapeutics.com**

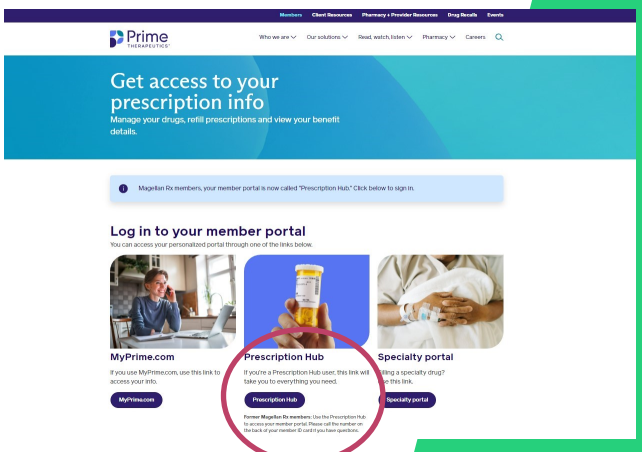
STEP 2. Click **MEMBERS** at the top of the screen

STEP 3. Click **PRESCRIPTION HUB** then click **REGISTER** and fill out the registration form.

STEP 1 & 2



STEP 3

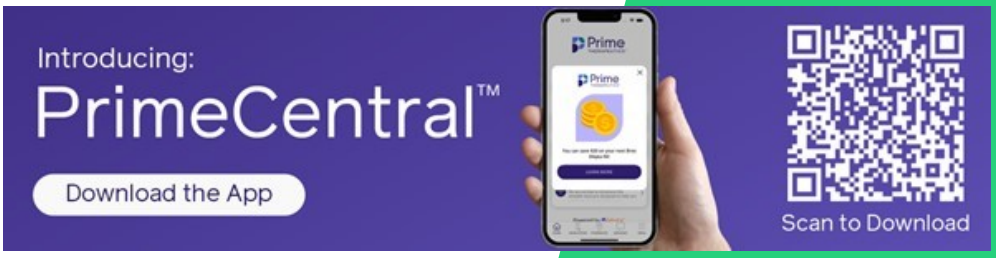


WHAT CAN I ACCESS ON THE MEMBER PORTAL?

- Find in-network pharmacies
- Compare prescription drug pricing
- Review prescription benefit coverage
- Review claims history

DOWNLOAD THE PRIME THERAPEUTICS MOBILE APP AND HAVE PRESCRIPTION RESOURCES AT YOUR FINGERTIPS!

- Check the status of your prescriptions
- Price a drug
- Get detailed clinical information regarding your prescription medication
- Receive notifications
- View Rx claims history



PHARMACY RESOURCES CONTINUED

If you take maintenance medications for long-term conditions such as arthritis, diabetes, high blood pressure or high cholesterol, Prime Therapeutics home delivery could be a fit for you. Through Prime Therapeutics' home delivery service, you can receive a 90-day supply of your maintenance medication mailed directly to your home.

HOW TO GET STARTED WITH HOME DELIVERY SERVICE

Follow these steps if you already have a 90-day prescription:

Mail your 90-day prescription and home delivery order form with payment information to:

Prime Therapeutics Pharmacy
P.O. Box 620968
Orlando, FL 32862

Follow these steps if you need a new prescription:

⇒ First, ask your doctor to write two prescriptions:

1. 30-day supply to fill right away at your local pharmacy
2. 90-day supply with refills to start your home delivery service

⇒ Next, ask your doctor to **e-prescribe** to Prime Therapeutics Pharmacy, LLC (Home Delivery, Orlando) or **fax** your prescription to (888) 282-1349.

HOW TO RECEIVE HOME DELIVERY REFILLS

ONLINE PORTAL

Submit your refill orders and pay online through your secure member portal at primetherapeutics.com/homedelivery.

PHONE

Call Prime Therapeutics at (800) 424-8274 (TTY 711) with your prescription number and payment information.

MAIL

Complete the refill section on the home delivery order form and mail it to:
Prime Therapeutics Pharmacy
P.O. Box 620968
Orlando, FL 32862

SPECIALTY DRUG RESOURCES

SPECIALTY MEDICATIONS—PAYDHEALTH

If you or an enrolled dependent take certain specialty medications, you may be eligible to participate in the Select Drugs and Products program through PaydHealth.

How the Program Works:

- Your provider will submit the prescription request and complete a prior authorization like they do today, then you will be contacted to enroll in the program
- If you are accepted into the plan, the program can substantially reduce your prescription cost—in some cases, no cost at all.

All specialty drugs on the plan's Select Drug and Products lists require clinical and administrative review, they must be medically necessary, and must be processed through the program before the benefit will be payable.

If you do not follow the process the medication will not be covered.

HOW TO GET STARTED

1. You will receive an outreach via text message or phone call from the Plan's Case Coordinator. ***You must respond to this inquiry within a timely manner in order to continue in the enrollment process.***

2. Complete the digital enrollment application which will allow the Plan's Case Coordinator to match you to alternate funding programs.
Note: you may be asked to provide household size and income information.

   You will also be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program from you and may require your prescribers participation as well.

   Being timely with your responses will help avoid any delays in processing your documentation.

3. Once necessary documents have been submitted, reviewed and the funding program is approved, your Case Coordinator will coordinate with you and your pharmacy to ensure you are able to receive your medications in a timely manner.

Case Coordinators are available 8:00 am — 8:00 pm (CST) to guide you through the enrollment process and the program. Be sure to respond to your Case Coordinator in a timely manner.

DENTAL INSURANCE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your benefits summary. You will get the most out of your dental benefits by visiting providers in the Delta Dental PPO or Delta Dental Premier network.

DELTA DENTAL®

	Dental Plan	
	In-Network *WHAT YOU PAY*	**Out-of-Network*** *WHAT YOU PAY*
Deductible		
Individual	$50	$50
Family	$100	$100
Covered Services		
Diagnostic & Preventive Services *(Cleanings, Exams, X-Rays)*	0%	0%
Basic Services *(Fillings, Root Canal Therapy, Oral Surgery)*	20%	20%
Major Services *(Extractions, Crowns, Inlays, Onlays, Bridges, Dentures, Repairs)*	50%	50%
Orthodontics *Up to age 19*	50%	50%
Maximum Benefit Limits *Includes Diagnostic, Preventive, Basic, and Major services*		
Annual Maximum *Per Person Per Calendar Year*	$1,500	$1,500
Lifetime Limit: Orthodontics *Dependents Under Age 19*	$1,000	$1,000

**When you receive services from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. The Non-Participating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.*

HOW TO FIND AN IN-NETWORK PROVIDER:

- Visit www.deltadentalin.com
- Click "Find a Dentist", then scroll down and click Search under Delta Dental PPO and Delta Dental Premier

GET THE MOST OUT OF YOUR BENEFITS

- By visiting in-network providers, you receive the highest level of coverage and reduce the chance of being balance billed for services.

DENTAL COVERAGE EXAMPLE

Below is an example of how you are billed and out-of-pocket expenses based on if you choose an out-of-network dentist versus a dentist in the Delta Dental PPO or Premier Network.

Delta Dental PPO Dentists	• No balance billing on covered services • **Most significant network discounts** with more than 395,000 office locations nationwide • Dentists file claims for members
Delta Dental Premier Dentists	• No balance billing on covered services • **Significant network discounts** with the most office locations nationwide - $460,000 • Dentists file claims for members
Out-of-Network Dentists	• Balance billing • **No network discounts** • May need to file own claims

HOW THE DENTAL PLAN WORKS*

Covered Services	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist **
	ADULT CLEANING		
Submitted Fee	$80	$80	$80
Maximum Allowed Fee	$54	$77	$63
Coverage Level *(Maximum of fee paid)*	100%	100%	100%
Amount Delta Dental Pays	$54	$77	$63
Amount You Pay	**$0**	**$0**	**$17**
	CROWN		
Submitted Fee	$1,100	$1,100	$1,100
Maximum Allowed Fee	$754	$989	$799
Coverage Level *(Maximum of fee paid)*	50%	40%	40%
Amount Delta Dental Pays	$377	$395.60	$319.60
Amount You Pay	**$377**	**$593.40**	**$780.40**

**The costs for services shown above are for illustrative purposes only.*

***When you receive services from an out-of-network dentist, the percentages in this column indicate the portion of Delta Dental's Out-of-Network dentist fee that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.*

VISION INSURANCE

Butler University wants to help protect the health of your eyes, that's why we provide vision insurance through **EyeMed**. To find out if your eye doctor is in-network, go to **www.eyemed.com**. Click Member Login to search for providers. If you go out-of-network, you will notice the details below show an "up to" amount. This is because you must pay the full cost of the service out of pocket, and then the insurance plan will reimburse you "up to" the defined amount. Look at your plan details for information on how to file for reimbursement.

Look for a participating providers at: **eyemed.com**

	Group Vision	
	In-Network	**Out-of-Network Benefits**
Eye Exams Covered Once Every 12 Months	$10 Copay	Up to $42
Frames Covered Once Every 24 months	$130 Allowance, then 20% off remaining balance	Up to $45
Lenses Covered Once Every 12 Months		
Single Lenses	$20 Copay	Up to $40
Bifocal Lenses		Up to $60
Trifocal Lenses		Up to $80
Lenticular Lenses		Up to $10
Contact Lenses* Covered Once Every 12 months *In Lieu of Glasses or Frames*		
Elective (Disposable)	$140 Allowance	Up to $135
Elective (Non-Disposable)	$140 Allowance, then 15% off remaining balance	Up to $135
Medically Necessary	0%; paid in full	Up to $210
Additional Benefits		
Standard Contact Lens Fitting and Follow Up	Discounted member cost not to exceed $40	
Second Pair Discount	40% off additional pairs of sunglasses 15% discount on conventional lenses once funded benefit is used 20% off any item not covered by the plan including non-prescription sunglasses	
Lens Options	Photochromic, Standard Polycarbonate (Adults)	
Retinal Imaging	Discounted member cost not to exceed $39	
LASIK or PRK from US Laser Network	15% off retail price or 5% off promotional price	

HEALTH SAVINGS ACCOUNT

Once your complete your benefits enrollment through my.butler.edu, if you elect the **HDHP-HSA Plan,** you are eligible for a Health Savings Account through **UMB. You are responsible for setting up your HSA account.**

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible care expenses are those that qualify toward the deductibles, copays, and coinsurance with your health plan.

COMPANY CONTRIBUTIONS

Butler University is pleased to continue contributing money to your HSA. Contribution amounts will be determined by your enrollment tier in the medical plan. You must set up your account through UMB in order for you to receive the company contributions. ***You must be enrolled in the HDHP-HSA medical plan in order have an HSA account and receive company contributions.***

NEW FOR 2025

****Butler University Employer contributions will be distributed on a per pay basis.***

2025 HSA Contributions			
	Butler University Contribution*	**Max Employee Contributions****	**2025 IRS Max Contributions**
Employee Only	$750	$3,550	$4,300
Family	$1,500	$7,050	$8,550
55+ Catch-Up	N/A	$1,000	$1,000

***Your total maximum contribution into the HSA may not exceed the IRS Contribution Limit for 2025 as shown above.*

MEDICARE

If you are enrolled in a Medicare plan, you are **not eligible to contribute to an HSA.** However, premiums for Medicare Part A, B, C and D can be reimbursed from an HSA. Medicare supplement insurance is not eligible for reimbursement.

MAXIMIZE YOUR TAX SAVINGS WITH AN HSA

use

You may use your HSA funds to pay for eligible healthcare expenses such as deductibles, doctor's office visits, dental expenses, eye exams and prescriptions.

save

Your HSA can help you prepare for the unexpected. Funds in your HSA roll over year-over-year and are yours to keep, even if you change health plans or jobs.

invest

You may invest and grow the money in your HSA-tax free, including interest and investment earnings. After you reach age 65, your HSA dollars can be spent without penalty on any qualified expense.

SETTING UP YOUR HSA ACCOUNT

UMB

UMB administers your Health Savings Account. You must first set up your account before company contributions and your contributions can be deposited.

OPENING YOUR HSA ONLINE

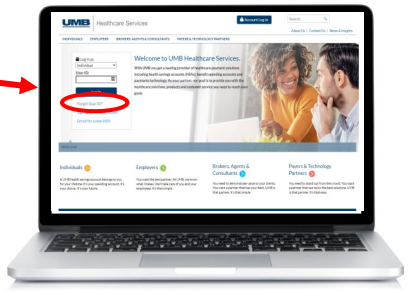
If you already have an HSA established with UMB, you do not need to do anything during open enrollment with your account.

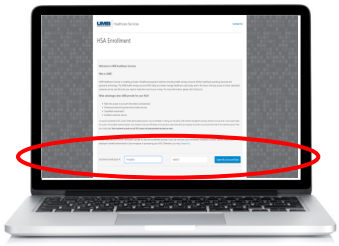
You will need the following information when you begin:

- Enrollment Verification Number: **THA0001 - 143674**

STEP 1.

Visit [hsa.umb.com](hsa.umb.com) and click **Enroll for a new HSA**





STEP 2.

Enter the Enrollment Verification #: **THA0001 - 143674**
Click **Open My Account Now**

The enrollment verification number is specific to Butler University.

STEP 3.

After you have clicked **Open My Account Now**, you will need to complete the following steps:

- Review the HSA eligibility requirements
- Read and accept the ESIGN agreement
- Review and accept the HSA Disclosure Documents
- Designate a beneficiary
- Enter your personal information into the secure HSA Enrollment Form
- Read and accept the Account Owner's Adoption and Enrollment Agreement
- Enrollment verification

After the enrollment process is complete, you will receive your UMB HSA Welcome Packet by mail in five to seven business days with detailed instructions on how to access your account online. **You will need your account number and debit card number to set up your password.**

STEP 4.

You can make changes to your employee election of your HSA at any time throughout the year without a qualifying life event. You can find the HSA election change form on the Benefits Hub.

Scan QR code for Benefits Hub

FLEXIBLE SPENDING ACCOUNT (FSA)

WHAT IS A FSA?

A FSA is a Flexible Spending Account (FSA) that allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

HOW DOES IT WORK?

You decide how much to contribute to your Health FSA on a plan year basis, up to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

You must enroll in the FSA each year. Elections do not carry over year-over-year.

CLAIM FILING AND REIMBURSEMENT

Your FSA administrator is WEX. In order to be reimbursed for your FSA expense, you must have an itemized receipt. To submit claims for reimbursement, simply complete a claim form, include a bill or itemized receipt from the provider, and submit this information for reimbursement.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO AN FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule; however, you may roll-over up to $660 year-over-year. Any funds above this amount will be forfeited.
- In order to be an eligible claim, it must have been incurred on or after the plan's effective date and prior to the end of the plan year.
- You cannot take income tax deductions for expenses you pay with your Health FSA and/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.

Annual Health FSA Maximum Contribution Limits	
2025	$3,300

Examples of Eligible Expenses:

Unreimbursed medical expenses (deductibles, coinsurance, copays, etc.)

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts and eye exams, Lasik eye surgery

DEPENDENT CARE FSA

WHAT IS A DEPENDENT CARE FSA?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or to care for a disabled spouse or dependent that allows you - or you and your spouse - to work.

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

Login to your WEX member account, complete the reimbursement form and include appropriate documentation.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as funds are "use it or lose it."
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (unless you experience certain qualifying life events).
- You may have a Health Savings Account and a Dependent Care FSA.
- The following contribution limits apply based on tax filing status:
    - Single: $5,000 maximum
    - Married filing separate: $2,500 maximum
    - Married filing jointly: $5,000 maximum
        - Total of any contributions by both towards the maximum
        - Example: Spouse 1 @ $1,000, Spouse 2 @ $4,000
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
    - Name (who received service)
    - Provider name (provider that delivered service)
    - Date of service
    - Type of service
    - Cost of service

EXAMPLES OF ELIGIBLE EXPENSES:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

In order to receive reimbursement for in-home babysitting fees, income must be reported as taxable income by the provider.

BUDGETING FOR YOUR CARE

The table below summarizes the key features of an HSA versus an FSA.

HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
HSA	**FSA**
HEALTH PLAN ELIGIBILITY Must be enrolled in the **HDHP-HSA** medical plan	**HEALTH PLAN ELIGIBILITY** Must be in enrolled in the **PPO Plus or** the **PPO Core Plan**
CONTROL Owned by the employee	**CONTROL** Owned by the employer
FUNDING Butler University & Employee funded *Butler University Funding* *Employee Only: $750* *All Other Tiers: $1,500*	**FUNDING** Employee funded
2025 CONTRIBUTION LIMITS $4,300 single; $8,550 family $1,000 more if age 55+	**2025 CONTRIBUTION LIMITS** Healthcare FSA: $3,300 Dependent Care FSA: $5,000
ROLLOVER AVAILABLE Yes, unlimited	**ROLLOVER AVAILABLE** Up to $660
CAN PARTICIPANTS INVEST FUNDS? Yes, when balance is at least **$2,000**	**CAN PARTICIPANTS INVEST FUNDS?** No
TAX ADVANTAGES Yes	**TAX ADVANTAGES** Yes

LIFE AND AD&D INSURANCE

Butler University provides basic life and AD&D insurance through OneAmerica to all benefits-eligible employees **at no additional cost**. You have the option to purchase additional voluntary life and AD&D insurance.

BASIC LIFE AND AD&D INSURANCE

Life insurance benefit provides a monetary benefit to your beneficiary in the event of your death while you are employed at Butler University. AD&D insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. It is important to keep your beneficiary information up to date.

- **Employee Life Benefit:** 1X annual base salary up to a maximum of $300,000
- **Employee AD&D Benefit:** 1X annual base salary up to a maximum of $300,000

Depending on your personal situation, basic life and AD&D insurance may not be enough coverage for your needs. To protect those who depend on you for financial security, you may want to purchase additional voluntary coverage.

VOLUNTARY LIFE INSURANCE

You have the opportunity to elect Voluntary Life Insurance. This will provide an additional life insurance benefit for you, your spouse and/or your dependent child(ren). You must purchase voluntary life coverage for yourself in order to purchase coverage for your spouse and/or dependents. Contributions for these premiums are 100% employee paid.

- **Employee:** $1,000 increments up to $500,000 (Minimum Election: $10,000); Guarantee Issue: $500,000. Benefit amounts will reduce beginning at age 70.
- **Spouse:** $1,000 increments up to $250,000 or 100% of employee's election, whichever is less (Minimum Election: $10,000); Guarantee Issue: $50,000. Benefit terminates at the end of the plan year a spouse turns age 70.
- **Dependent Child(ren):** <6 months of age: $1,000; 6 months and older: Guarantee Issue - $10,000 ***Benefit terminates at the end of the month a dependent turns age 26, or when married.***

If you wish to enroll in Voluntary AD&D Insurance, you may elect this benefit during your new hire enrollment/annual open enrollment.

If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. The carrier will review and determine approval based on EOI documentation.

IMPORTANT BENEFICIARY REMINDERS

- It is important to keep your beneficiary information up to date. Have you had a life event such as marriage, divorce, birth or death of a dependent?
- Insurance companies cannot give life insurance payouts directly to minor children. Any payout could be held up until a court-appointed custodian is brought in to oversee the funds, delaying payments to your family.

DISABILITY INSURANCE

Disability insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury. Butler University offers both Short-Term Disability and Long-Term Disability through OneAmerica to benefits-eligible employees **at no additional cost.**

WAITING PERIOD	SHORT-TERM DISABILITY INSURANCE	LONG-TERM DISABILITY INSURANCE
Short-Term Disability: 7 days **Long-Term Disability:** 91 days	Butler University automatically provides Short-Term Disability (STD) insurance to all benefits-eligible employees. Benefits will be reduced by other income, including state mandated STD plan. **Benefit:** 60% of base pay, up to $3,000 per week **Elimination Period:** 7 days **Benefit Duration:** Up to 12 weeks	Butler University automatically provides Long-Term Disability (LTD) insurance to all benefits-eligible employees. **Benefit:** 60% of base pay, up to $14,000 per month less other income benefits. **Elimination Period:** 90 days
COMPANY PAID		

For eligibility requirement and more information regarding these income continuation benefits, please contact Benefits & Wellness at benefits@butler.edu.

NEED A LEAVE OF ABSENCE?

Contact Benefits & Wellness to discuss your need for a leave of absence, benefits@butler.edu.

Scan the QR to easily start your email to Benefits & Wellness.

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EMPLOYEE ASSISTANCE PROGRAM

You and your family are important to us, which is why we provide every employee access to our Employee Assistance Program (EAP). This program provides services that helps you manage life situations before they adversely affect your personal life, health, and job performance.

SERVICES PROVIDED

ComPsych Guidance Resources provides in-person and 24/7 online services for individuals, married couples, and families for a variety of situations. Common situations included, but are not limited to:

- Anxiety
- Depression
- Stress
- Life Changes / Adjustments
- Marital / Family Issues
- Legal Assistance
- Financial assistance
- Grief Loss
- Interpersonal / Communication Issues

FREE SERVICES

Each eligible family member may receive up to 6 face-to-face counseling sessions and 24/7 telephonic counseling, work/life balance resources.

CONFIDENTIALITY

Services provided by ComPsych are completely confidential. No information, including your name, can be released with your written consent.
The only exception would be when it is the duty of the counselor to warn someone of a serious threat or the mandated reporting of child or elder abuse.

GETTING STARTED

- Call (855) 365-4754

or

- Visit www.guidanceresources.com
    - **Web ID:** ONEAMERICA6

403B RETIREMENT

Retirement Plan Contributions and Match—TIAA

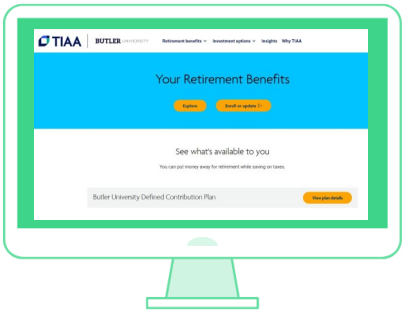
Butler University wants to assist employees in their effort to save for retirement and provides an opportunity for employees to make pre-tax contributions to the Butler University 403(b) Retirement Plan administered by TIAA. Eligible employees can enroll in the plan the month following the date of hire to begin making employee deferral pre-tax contributions.

If you are an eligible full-time employee, complete a year of service, and make the required 5% pre-tax employee contribution to the plan, the University will make a discretionary matching 10% contribution to the plan on your behalf. Employees will make their salary deferral election(s) for the retirement plan by setting up an account with TIAA and following the online salary deferral election instructions. Please follow the instructions below to get started.

Butler employees who are less than full-time can contribute to their retirement account with employee pre-tax deferrals and can enroll in the plan the month following the date of hire. The employer match will not apply to employees working less than full-time. Employees are always 100% vested in all plan accounts through Butler's TIAA retirement plan.

(More information available at www.butler.edu/human-resources/benefits/financial/retirement-savings-plan.)

HOW TO ACCESS YOUR RETIREMENT ACCOUNT ONLINE



- Go to **www.TIAA.org/butler**
- Click **ENROLL OR UPDATE**
- If you are a first-time user: Click **Register** with TIAA to create your user ID and password
- If you are a returning user: Enter your TIAA user ID and click **Log In**
- Follow the prompts and print out the confirmation page. You are now enrolled.
  Important: *Employees are eligible to make contribution elections online at any time. Please be aware that there are election deadlines required for processing online elections. Review the payroll date and election date schedule provided on the TIAA website.*
- Remember to balance out your supplemental retirement plan contribution so that you do not reach the annual IRS limit too soon. When this happens ALL your contributions are terminated, and you might miss out on the 10% employer match that you are eligible for.

HOW TO CHANGE INVESTMENTS OR TRANSFER FUNDS

- Go to **www.TIAA.org/butler**, click Log In, then enter your TIAA user ID and password
- In the **My Account** drop-down menu, select **Manage Investments**
  - **To Change Investments for Future Contributions:** Select **Change Allocation of Contributions** and select each account/contract you would like to update and enter your investment instructions.
  - **To Transfer Funds:** Select **Change My Investments** and select each account/contract you would like to update and enter your investment instructions.

HOW TO CHANGE BENEFICIARY DESIGNATION

- Go to **www.TIAA.org/butler**, click Log In, then enter your TIAA user ID and password
- In the **My Account** drop-down menu, select **Change Beneficiaries**

Coming Soon!

★ Stay tuned for more details!

DIATHRIVE HEALTH

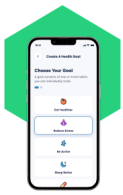
UNLIMITED DIABETES CARE. FREE TO YOU!

Are you diabetic or pre-diabetic? Keeping diabetes under control can greatly reduce the risk of complications. Diathrive Health's diabetes management program helps you handle your diabetes with the help of Diathrive Health Advisors—experts in diabetes care, registered nurses, and dieticians who provide clinical advice.

THE SOLUTION:

UNLIMITED SUPPLIES

You get access to ***unlimited supplies*** with NO out-of-pocket cost so you always have what you need to check blood sugar and get the info to make health decisions.



DIATHRIVE HEALTH APP

The Diathrive Health mobile app is the hub for everything you need.

- Sync and review health data
- Reorder supplies
- Access our library of educational videos and articles
- Connect with a personal ***Health Advisor***

HEALTH ADVSIOR

More than just health coaching—you get a personal ***Health Advisor*** who reviews your health data, identifies any personal challenges, and helps create a custom care plan for you.

SWORD HEALTH

Sword Thrive: Relieve aches + pains from the comfort of your home.

Tired of experiencing chronic pain or loss of mobility? Struggling with discomfort? Meet **Sword Thrive**, your new digital physical therapy program designed to help you overcome joint, back, and muscle pain— all from home. Combining licensed physical therapists (PTs) with easy-to-use technology, Thrive is more than just convenient, it is proven to work.

Here's how it works:

PICK YOUR PT
Thanks to your dedicated PT, your Thrive program is entirely customized to you, your goals and your abilities.

GET YOUR THRIVE KIT
Your kit comes with your own tablet, and will provide you and your PT with real-time feedback.

STAY CONNECTED
Chat 1:1 with your PT anytime. They'll check in, monitor your progress, and adjust your program as needed.

FEEL THE RELIEF
Complete your exercise sessions whenever is most convenient for you. Then feel pain relief for yourself.

Plan Notices, Disclosures & Legal Documents

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your **Plan Administrator** as follows:

Butler University
Benefits & Wellness
4600 Sunset Avenue
Indianapolis, IN 46208
(317) 940-9355

Name of Group Health Plan: Butler University Employee Benefit Plan

Notice Regarding Special Enrollment Rights

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

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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

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.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section). Special enrollment can be completed through my.butler.edu.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

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. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

Notice Regarding Michelle's Law

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

Notice Regarding Patient Protection Rights

Your Group Health Plan (identified at the beginning of this section) generally allows 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. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Group Health Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the Plan Administrator (identified at the beginning of this section) or issuer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

Health Insurance Marketplace Coverage Options and Your Health Coverage

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.5% (indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.5% (indexed annually) of the employee's household income. (An employer-sponsored or other employment-based 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 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Plan Administrator (identified at the beginning of this section)..

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

***When balance billing isn't allowed, you also have these protections*:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at https://www.cms.gov/nosurprises/consumers. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

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

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

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

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

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

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

ALABAMA Medicaid	**ALASKA Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**INDIANA Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)	KANSAS Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA Medicaid and CHIP	RHODE ISLAND Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
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

Turning Age 65 and Becoming Medicare Eligible

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage and Part D (prescription drug) coverage at your cost. If you do enroll in Medicare, this plan and Medicare will coordinate benefits with one plan paying as primary and the other paying as secondary, as determined by Federal law. When Medicare is primary, some carriers require the participant enroll in Medicare Part B; members should call their medical carrier member services line to identify when this is required.

For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner, or any dependent resides at a different address then you, please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) 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. The prescription drug coverage offered by the Group Health 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 U.S. Social Security on the web at **www.socialsecurity.gov** or call 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).

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on my.butler.edu. A paper copy is also available, free of charge, by contacting your Plan Administrator (identified at the beginning of this section).

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