SPALDING UNIVERSITY

Employee Benefit Guide

2025-2026

Faculty

Welcome to your 2025-2026 Employee Benefits!

Spalding University recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

For any questions about the benefits outlined in the guide, please contact your Human Resources Department.

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Your company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

What's Inside

Carrier Contacts 2

AP Assist 3

Eligibility 4

Benefit Change in Status 5

Medical Insurance 6

Which Health Plan is right for you? 7

TrueRx 8

Sydney Health 9

Health Savings Accounts 10-11

Flexible Spending Account 12

Where to Go 13

Dental Insurance 14

Vision Insurance 15

Disability Insurance 16

Basic Life and AD&D 17

Voluntary Life and AD&D 17

403(b) Retirement 18

Paid Time Off 18

Other University Benefits 18

Tuition Benefits 19

Employee Assistance Programs 20

Travel Assistance 21

Compliance Notices 22

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

Spalding University Carriers	Group #	Website	Phone
Medical Aspirant	00SWG834	www.aspirant.us spaldingmember@aspirant.us	1.855.982.2583
Specialty Drug Program TrueRx		www.truerx.xom	1.866.921.4047
Dental Delta Dental of Kentucky	004000007	www.deltadentalky.com	1.800.955.2030
Vision Delta Vision	70700V	www.vsp.com	1.800.955.2030
HSA & FSA McGregor & Associates		https://mcgregoreba.com/	1.859.233.4377
Basic Life and AD&D One America	625154	www.oneamerica.com	1.800.553.5318
Voluntary Life and AD&D One America	625154	www.oneamerica.com	1.800.553.5318
Short-Term Disability One America	625154	www.oneamerica.com	1.800.553.5318
Long-Term Disability One America	625154	www.oneamerica.com	1.800.553.5318
Retirement TIAA Association of Kentucky Colleges and Universities		www.tiaa.org/aikcu	1.800.842.2552

AP Assist

Customer Resource Center

The AP Assist team is a year-round customer resource center available to employees of Spalding University comprised of experienced and helpful benefits counselors that will:

- Assist with understanding plan benefits and eligibility rules
- Help with understanding EOB's and other plan materials
- Assist with billing and enrollment issues
- Work with the insurance companies to resolve claims and billing issues
- Provide information about benefits options after a life event like marriage, birth, death, divorce, job change
- Assist in obtaining member ID Cards

Monday through Friday 8:30 AM - 5:00 PM (EST)
EMAIL: apassist@assuredpartners.com
PHONE: 833-664-7195

AssuredPartners

AP Assist	apassist@assuredpartners.com	833-664-7195

Eligibility

Spalding University shares in the cost by paying for a portion of the employee and dependent health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period, unless the change is due to and consistent with a family/life status change.

Who is eligible for Benefits?

- For new employees working 30 hours per week, benefits begin on the first of the month following date of hire.
- All current employees working 30 hours per week.

Eligible Dependents

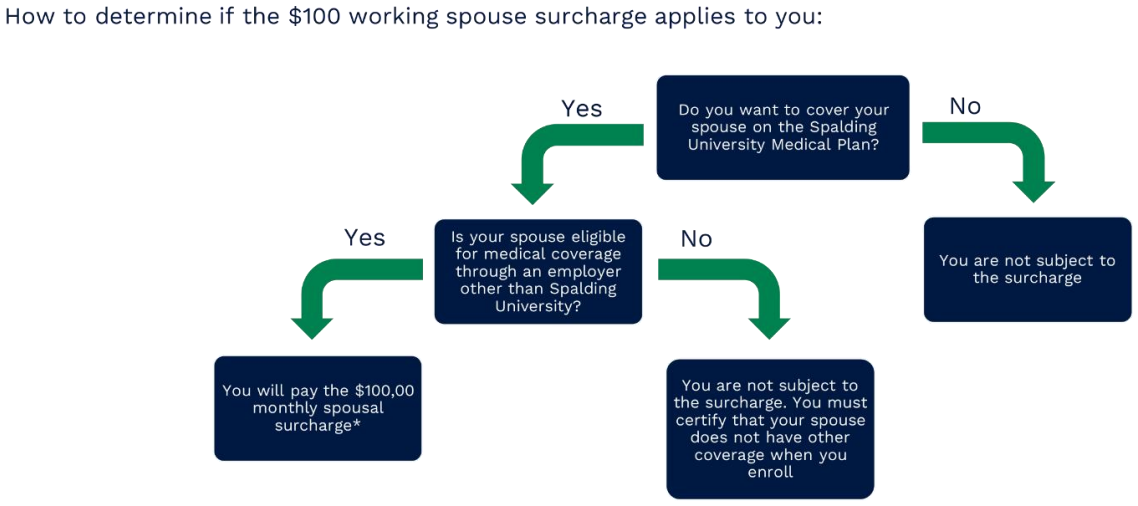
- A spouse whom you are legally married
- A dependent child under the age of 26. Coverage terminates at the end of the month of the dependents 26th birthday

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Working Spouse Surcharge*

If you choose to enroll your spouse on Spalding University's Medical Plan, you may be subject to a $100 monthly surcharge. Please see the flowchart below to determine if the working spouse surcharge applies to you:



**You are exempt from the surcharge if your spouse's employee coverage has an annual out-of-pocket maximum greater than $6,250 (employee only) and $12,500 (if covering dependents)*

Please Note: *If you cover an individual on your benefit plan who is not an eligible dependent, this is considered fraud and theft. Claims may be reprocessed and become your responsibility. Providing false statements regarding Tobacco usage is against company policy. Anyone found providing false statements will be subject to discipline up to and including termination of employment.*

Benefit Change in Status

Spalding University sponsors a cafeteria plan which allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for some or all of those benefits with pre-tax dollars.

Participant elections made under a cafeteria plan are generally irrevocable and run from the beginning of the Plan Year (or date of initial eligibility) through the end of the Plan Year. With the exception of HSA contribution elections, you will not be able to change or revoke your elections during the Plan Year unless you experience an IRS permitted qualifying event. Any change you make must be consistent with the qualifying event. Examples of qualifying events that may entitle you to make a mid-year change in your election during a Plan Year, include:

- Birth / Adoption
- Divorce
- Death
- FMLA Related Leave
- Dependent Child Age Limit
- Marriage
- Loss of Coverage
- Eligible for Medicare

Employers do not have to permit any exceptions to the election irrevocability rule for cafeteria plans. Please consult your Plan Administrator for the specific qualifying events permitted by your plan.

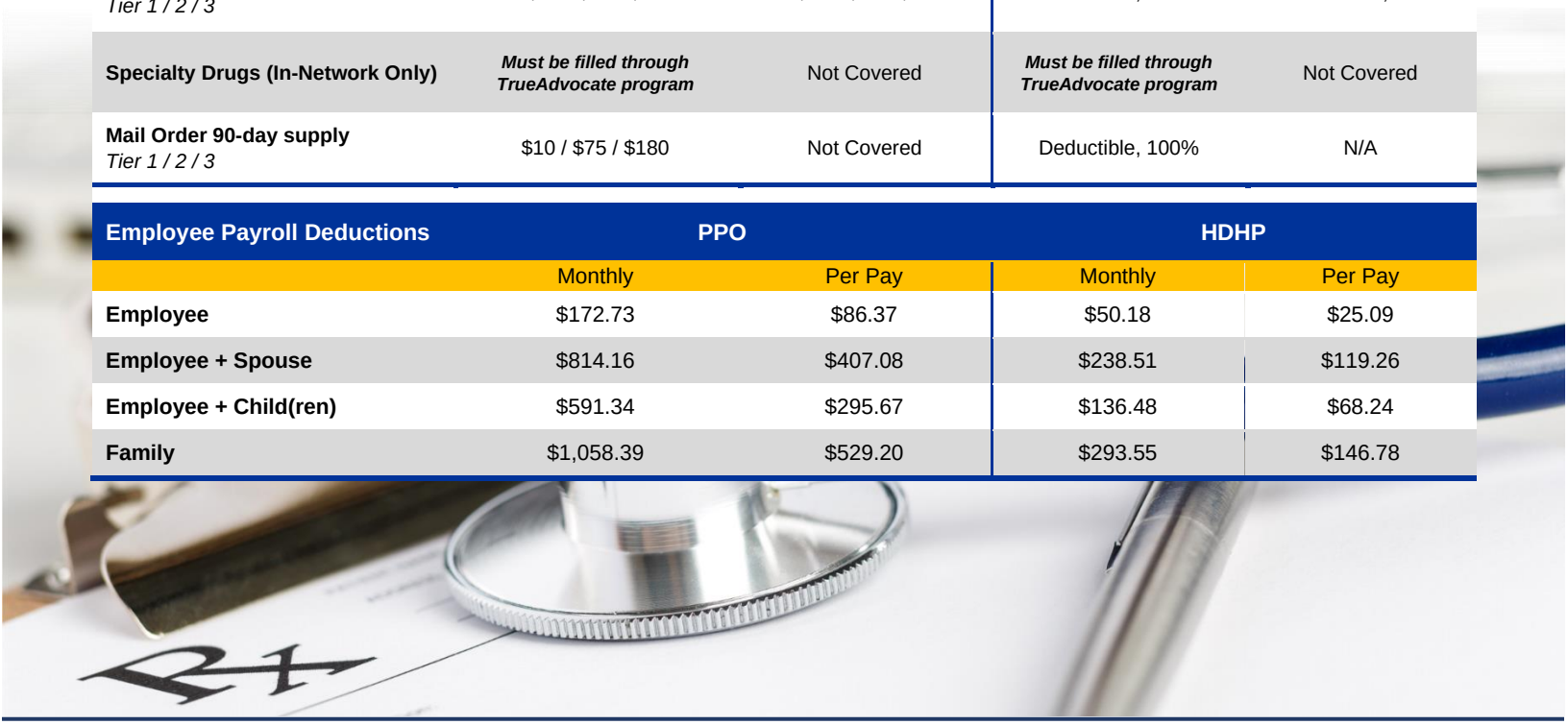
You must notify your Human Resources Department within 30 days from the Status Change in order to make a change in your benefit selections.

Medical Insurance

Anthem medical plans offer freedom of choice with access to a large national network of physicians, hospitals and health care professionals (clinics, labs, care centers, etc.). All employees who enroll in either of the medical plans will automatically be enrolled in an additional $15,000 of term life insurance through Anthem. The medical plans are administered through a 3rd party administrator called Aspirant. To find a network provider, visit www.aspirant.us or call Aspirant Services at 1.877.309.2955.

	PPO		HDHP	
	In-Network	Out of Network	In-Network	Out of Network
Deductible *(Individual / Family)*	$2,000 / $6,000	$4,000 / $12,000	$4,000 / $8,000	$8,000 / $16,000
Out of Pocket Maximum *(Individual / Family)*	$3,000 / $9,000	$9,000 / $27,000	$4,000 / $8,000	$15,000 / $30,000
Physician Office Visits *Primary Care / Specialist*	$25 Copay $40 Copay	Deductible, 40%	Deductible, 100%	Deductible, 40%
Preventive Care	Covered In Full	Deductible, 40%	Covered In Full	Deductible, 40%
Emergency Room Copay	$150 Copay	$150 Copay	Deductible, 100%	Deductible, 40%
Urgent Care Copay	$40 Copay	Deductible, 40%	Deductible, 100%	Deductible, 40%
Inpatient & Outpatient Professional Services	Deductible, 85%	Deductible, 40%	Deductible, 100%	Deductible, 40%
Outpatient Surgery Hospital / Alternative Care Facility	Deductible, 85%	Deductible, 40%	Deductible, 100%	Deductible, 40%
Prescription Drugs	**Separate $3,600 / $4,200 OOP*			
	In-Network	Out of Network	In-Network	Out of Network
Retail 31-day supply *Tier 1 / 2 / 3*	$10 / $35 / $60	$10 / $30 / $60	Deductible, 100%	Deductible, 40%
Specialty Drugs (In-Network Only)	***Must be filled through TrueAdvocate program***	Not Covered	***Must be filled through TrueAdvocate program***	Not Covered
Mail Order 90-day supply *Tier 1 / 2 / 3*	$10 / $75 / $180	Not Covered	Deductible, 100%	N/A

Employee Payroll Deductions	PPO		HDHP	
	Monthly	Per Pay	Monthly	Per Pay
Employee	$172.73	$86.37	$50.18	$25.09
Employee + Spouse	$814.16	$407.08	$238.51	$119.26
Employee + Child(ren)	$591.34	$295.67	$136.48	$68.24
Family	$1,058.39	$529.20	$293.55	$146.78



Which Health Plan is right for you?

Both of your medical plan options offer the same network of providers and cover the same services, but your out of pocket expenses are handled differently. The below grid breaks down the differences between the plans:

PPO

(Preferred Provider Organization)

- **Copays** are flat dollar amounts that you will pay for certain services like office visits and prescriptions.
- You will pay for the entire out of pocket cost for non-copay items like hospitalization and surgeries until you meet your **deductible**.
- **Copays do not apply to your deductible**.
- **Coinsurance** is the percentage of costs that you share with the insurance plan after your deductible has been met.
- The **Maximum Out of Pocket** is the maximum amount you will pay during the benefit period. All remaining covered services are paid in full by the plan.

HDHP

(High Deductible Health Plan)

- Generally, HDHP plans **do not feature copays** for medical or pharmacy services.
- You will pay out of pocket for **all medical and prescription expenses** until you meet your **deductible**. Then the plan will begin to pay.
- **Coinsurance** is the percentage of costs you share with the insurance plan after your deductible has been met.
- The **Maximum Out-of-Pocket** is the maximum amount you will pay during the benefit period. All remaining covered services are paid in full by the plan.

Questions to Consider:

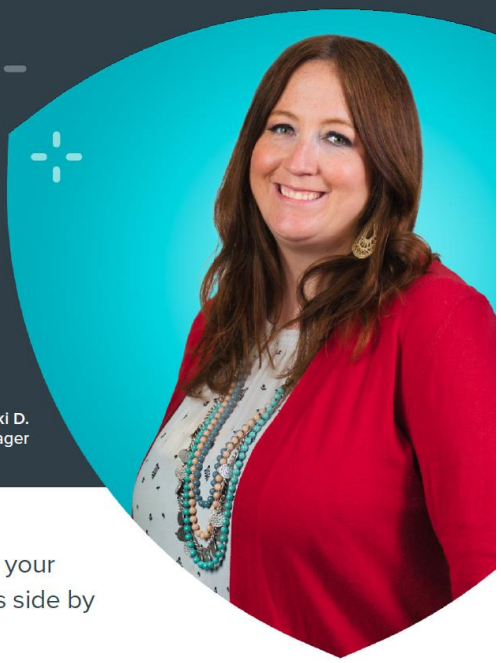
- Are you or a dependent managing a chronic condition that requires consistent office visits outside of regular preventive care?
- Do you anticipate filling prescriptions regularly?
- Are you more comfortable with higher premium costs and lower out of pocket exposure or lower premium costs and higher out of pocket exposure?

For more specific plan comparison details, view your carrier benefit summaries

AssuredPartners

trueAdvocate

Personalized care for patients taking specialty medication



Nikki D.
True Rx Specialty Case Manager

True Advocate is a specialty medication program designed to help lower your prescription cost. True Rx provides a dedicated case manager who works side by side with you to ensure great care.

Your Dedicated Case Manager Will

1. **CONTACT** you to provide introductory information about the program and answer any questions.
2. **SEND** the Advocacy application form to you.
3. **CONTACT** the doctor requesting necessary information about your prescription(s).
4. **SUBMIT** the completed application and communicate with the assistance program that all necessary information is received for processing and approval.
5. **COORDINATE** all steps to ensure you receive medication on time.

If your specialty medication cannot be sourced in the United States, your specialty case manager will help you fill your medication through an international, Tier 1 pharmacy. The source will be as safe and effective as a US-based source. Your specialty case manager will guide you through the process and answer all of your questions.

Your cost of the medication is typically approved for $0 for one year by the assistance program. Your medication is delivered directly to you.

We're here to answer any additional questions.

Reach us at **hello@truerx.com** or **866-921-4047**.

trueRx HEALTH STRATEGISTS
866-921-4047
hello@truerx.com
truerx.com

Sydney Health

Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar **anthem.com/es**.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at **anthem.com/register** to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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Health Savings Accounts

Please note that the HSA is only available for employees who are enrolled in the anthem HDHP core plan.

Employees who choose to enroll in the high deductible health plan (HDHP) are automatically eligible for the following: enrollment in a health savings account HSA. Spalding will contribute $25 per month ($12.50 per pay period) to the HSA account; the employee may also contribute their own funds up to a maximum deferral amount this account is managed by McGregor employee solutions.

What is a High Deductible Health Plan

A HDHP is a plan with a certain annual deductible amount and a maximum out-of-pocket limit as listed below:

- In-Network Deductible: $4,000 Single/$8,000 Family
- In-Network Out-of-Pocket Maximum: $4,000 Single / $8,000 Family Out-of-Pocket Max includes the Deductible)

Sometimes referred to as consumer-driven health insurance, a HDHP still covers you for catastrophic illness and injury—what health insurance was originally intended to do.

Office visits and prescription drugs are subject to the deductible. This means you pay a negotiated discount price instead of a fixed co-pay until you reach your deductible.

What is a Health Savings Account (HSA) and how does it work?

A Health Savings Account is a tax-advantaged trust account that allows you to take charge of your health, your savings and your future.

It allows you to put away tax-free dollars to help pay for your eligible healthcare expenses including medical, prescription drugs, dental, vision, certain premium expenses like COBRA and Medicare premiums, etc., both today and in the future.

The 2025 maximum annual contribution to an HSA is $4,300 for single coverage and $8,550 for family coverage (combined between yourself and “the company”). The IRS determines the contribution maximums annually.

Advantages of an HSA

- Money you put into your account is deducted pretax therefore reducing your taxable income.
- Money that stays in your account earns tax-free interest.
- Money you pay from your account to pay for your qualified healthcare expenses is not taxed.
- Money rolls over from year-to-year – no “use it or lose it” restriction.

Who is eligible for an HSA?

- You must be enrolled in a qualified High Deductible Health Plan (HDHP).
- You cannot be covered by any other health plan that is not a qualified HDHP (certain exceptions). Disqualifying health plans include general-purpose health FSAs and HRAs provided by your employer or your spouse’s employer.
- You cannot be enrolled in Medicare or receiving Social Security.
- You cannot be claimed on another person’s tax return.
- You have not received VA medical benefits at any time over the past three months.

Basic Benefits of the High Deductible Health Plan

- Visits to any doctor or facility for covered service, just as usual.
- Your plan includes deductibles, coinsurance and a limit on what you pay out-of-pocket.
- Annual routine preventive care services are included in your plan. You generally do not pay for these services; not even an office visit co-pay.
- Certain Preventive Prescriptions are also included. On these the deductible is waived and you only pay the coinsurance.

When do I use my HSA?

After visiting a physician, facility, or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles and coinsurance) billed by the physician, facility, or pharmacy, or you can choose to save your HSA dollars for a future medical expense. In addition, HSA dollars are available to pay for dental, vision and other expenses as well.

How does the HDHP Deductible Work?

Under the HDHP, your annual deductible and out-of-pocket maximum includes both medical and pharmacy expenses. All expenses are your responsibility until the deductible is reached (except qualified preventive care). For single coverage, your annual deductible is $4,000 per covered person per year. For family coverage, the annual deductible is $8,000 per calendar year for all covered persons in a family. For family coverage, expenses are your responsibility until the entire family deductible is satisfied. One or more persons may satisfy the family deductible.

Health Savings Accounts *continued*

How are benefits covered after the deductible is satisfied?

Once you have satisfied the in-network deductible, remaining qualified expenses are covered by the HDHP plan at 100%t up to the out-of-pocket maximum. The in-network out-of-pocket maximum (including the deductible) is $4,000 for single coverage and $8,000 for family coverage.

How does the HDHP work if I go out-of-network?

Out-of-network coverage is covered in the same manner as it is today under your current PPO plans. You must satisfy the out-of-network deductible then expenses are covered at the out-of-network coinsurance level of 60%.

Can ineligible expenses be reimbursed from an HSA?

Ineligible disbursements from an HSA are subject to a 20% penalty. Neither the trustee, bank, insurance company nor Spalding University are required to determine if a claim submitted for reimbursement is a qualifying medical expense.

The employee is responsible to include the amount withdrawn from an HSA for a non-qualifying medical expense is added to the account beneficiary's income and subject to a 20% penalty. Where funds are distributed as a result of the account beneficiary's death, disability, or after he or she is eligible for Medicare, the 20% penalty does not

Why should I elect an HSA?

- Tax Benefits
  - ✓ HSA contributions are excluded from federal income tax
  - ✓ Interest earnings are tax-deferred
  - ✓ Withdrawals for eligible expenses are exempt from federal income tax

- Unused money is held in an interest-bearing savings or investment account
- Lower employee contribution
- Company contribution

Long-Term Financial Benefits

- Save for future medical expenses
- Funds roll over year to year
- This is your account, you take it with you if your employment at Spalding University ends.

Choice

- You control and manage your healthcare expenses.
- You choose when to use your HSA dollars to pay for your healthcare expenses.
- You choose when to save your HSA dollars and pay healthcare expenses out of pocket.

Who will administer the HSA?

Wage Works administers the HSA bank accounts for Spalding University employees that are enrolled in the qualified High Deductible Health Plan.

Flexible Spending Account (FSA)

What is a Flexible Spending Account (FSA)?

Flexible spending accounts, or FSAs, provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income. It is important to plan carefully, because FSA funds not spent during the plan year are forfeited.

Essentially, the Internal Revenue Service (IRS) set up FSAs as a means to provide a tax break to employees and their employers. As an employee, you agree to set aside a portion of your pretax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state or local income taxes – effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you incur, your spendable income will increase.

Flexible Spending Accounts

General Purpose FSA

The General Purpose FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pretax dollars. For example, cash that you now spend on deductibles, copayments or other out-of-pocket medical expenses can instead be placed in the health care reimbursement FSA pretax.

Eligible Expenses

Eligible health care expenses for the health care reimbursement FSA include more than just your deductible and copayments. You can spend FSA funds on prescription medications, as well as over-the-counter medicines with a doctor's prescription. Reimbursements for insulin are allowed without a prescription. FSAs may also be used to cover costs of medical equipment like crutches, supplies like bandages, and diagnostic devices like blood sugar test kits.

Note: ***Employees enrolled in the HDHP plan are eligible for the Limited Purpose FSA, to comply with HSA rules.***

Limited Purpose FSA

A limited-purpose health flexible spending account (FSA) is much like a traditional, general-purpose health FSA. It's an account you elect to set aside pre-tax dollars to pay for certain health care expenses. Unlike a general-purpose health FSA, however, funds in a limited-purpose health FSA can only be used to pay for qualifying dental, vision and orthodontia expenses such as dental and vision deductibles, exams, cleanings, x-rays, fillings, crowns and other orthodontia work, contacts and eyeglasses, and more. It is set up in this way so that it can be used alongside a Health Savings Account (HSA).

Other than the restriction of eligible expenses to vision, dental and orthodontia, the rules governing the limited-purpose health FSA are the same as those that apply to the general-purpose health FSA.

The Dependent Care FSA

The Dependent Care FSA lets you use pretax dollars toward qualified dependent care. The annual maximum amount you may contribute is $5,000 (or $2,600 if married and filing separately) per calendar year.
If you elect to contribute to the dependent care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Eligible Expenses

In order for dependent care services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours – instances such as Saturday night babysitting does not qualify – and cannot be provided by another of your dependents.

2025 Contribution Limits

Health FSA	**$3,300**
Dependent Care	**$5,000**

Carryover: unused funds up to a max of **$640** can be carried over from one plan year to the next.

After the end of the plan year, there is a 90 day runout period to submit any claims incurred during the plan year for reimbursement (if you terminate employment, there is a 0 day runout period)

Where to Go

	Conditions Treated	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns	• Costs are highest • No appointment needed • Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Joint pain • Minor respiratory symptoms	• Costs are lower than an ER visit • No appointment needed • Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	• General health issues • Preventive services • Routine checkups • Immunizations and screenings	• May include coinsurance and/ or deductible • Appointment usually needed • May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccinations	• Costs are same or lower than office visit • No appointment needed • Wait times typically 15 minutes or less
Live Health Online		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	• Cold and flu symptoms such as a cough, fever and headaches • Allergies • Sinus infections	• Cost is lower than office visit • No appointment needed • Immediate, private, and secure visits

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

Dental Insurance

With Delta Dental you have freedom of choice when selecting a dentist. To find a participating dentist in the Delta Premier network, visit www.deltadentalky.com or call 800-955-2030.

The dentist you select will determine the cost savings you receive when seeking care. You may choose any dentist, even if they do not participate in Delta Dental's network.

Non-participating dentists are not contracted to accept Delta Dental negotiated fees as payment in full. If you choose a non-participating dentist, you will be responsible for any charges above Delta Dental's negotiated fee. You may also be required to pay in full at the time of service and submit a claim form to Delta Dental for reimbursement. Then the benefit payment will be mailed to you directly.

	Cost Share Plan	PPO Plan
	In-Network	In-Network
Deductible	$50 Single / $150 Family	$50 Single / $150 Family
Maximum Benefit	$1,000	$1,000
Diagnostic & Preventive Services *(Exams and X-rays)*	Covered in Full, deductible waived	Covered in Full, deductible waived
Basic Services *(Routine fillings, simple extractions, oral surgery)*	Not Covered	50%, subject to deductible
Major Services *(Crowns, dentures, bridges, and implants)*	Not Covered	50%, subject to deductible
Orthodontic Services *(dependent children through age 18 and under)*	Not Covered	50%, deductible waived

Employee Payroll Deductions	Low Plan		High Plan	
	Per Pay	Monthly	Per Pay	Monthly
Employee	$4.80	$9.60	$11.90	$23.79
Employee + Spouse	$10.44	$20.87	$20.12	$40.23
Employee + Child(ren)	$9.91	$19.81	$22.91	$45.82
Family	$17.51	$35.02	$37.49	$74.97

Vision Insurance

DeltaVision®
In partnership with VSP®

Spalding University provides employees with vision coverage through Delta Vision. The Delta Vision Plan utilizes the VSP national network and provides rich, flexible vision plans covering exams and materials, making it more affordable to keep your eyes healthy. For more information or to locate a participating provider please visit www.vsp.com or call 1.800.955.2030.

	Network	Out of Network
Routine eye exam *(every 12 months)*	$10 copay	Up to $45
Eyeglass Frames *(every 24 months)*	$130 frame allowance, then 20% off on amount over allowance $70 Costco allowance	Up to $70
Standard Plastic Lenses		
Single	$25 Copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Lenticular		Up to $100
Standard Progressive		Up to $50
Contact Lenses *(every 12 months)*	In lieu of eye glasses	
Conventional	$130 allowance	Up to $105
Medically Necessary	Covered in Full	Up to $210

Employee Payroll Deductions		
	Per Pay	Monthly
Employee	$3.15	$6.30
Employee + Spouse	$6.30	$12.60
Employee + Child(ren)	$6.75	$13.49
Family	$10.78	$21.55

Disability Insurance

Spalding Policy Manual, Volume III, 3.3.2.1.3

After 12 continuous months of employment, the university offers up to six weeks of paid time off for any major surgery, illness, childbirth, or adoption annually at no cost to the employee. You must use 10 days of your own PTO first period after the six weeks, an employee may use vacation, sick time, or other disability insurance if needed. The university reserves the right to request information from the attending physician.

Short Term and Long Term Disability

Whether you are totally disabled and unable to work due to an accident or illness, Spalding University provides disability benefits. Spalding University pays the full cost of coverage for long term disability. Additionally, you have the option to purchase a buy up Long Term Disability policy and Voluntary Short Term Disability policy. Long Term Disability benefits will provide for a percentage of your salary once you've satisfied the waiting period. Voluntary Short Term disability begins after the exhaustion of the above mentioned Spalding policy manual, volume III, 3.3.2.1.3 benefit.

Short Term Disability		
	Class 1 *Employees with **less** than 12 months tenure*	**Class 2** *Employees with **more** than 12 months tenure*
Waiting Period	15th Day after your accident or illness	56th Day after your accident or illness
Maximum Benefit Duration	24 weeks	18 weeks
Maximum Benefit You Receive	60% of weekly salary to a max of $750	60% of weekly salary to a max of $750

Long Term Disability		
	Employer Paid	**Buy Up** *Employee Paid*
Benefits Begin	180 days	180 days
Maximum Benefit Duration	Later of 65 or Social Security Normal Retirement Age (SSNRA)	Later of 65 or Social Security Normal Retirement Age (SSNRA)
Percentage of Income Replaced	60% of your earnings to a maximum of $5,000.	70% of your earnings to a maximum of $5,000.

Basic Life and AD&D Insurance

Spalding University provides Basic Life and AD&D in the amount of one (1) times your annual earnings to a maximum of $500,000. There is no cost to you for this coverage. Benefits reduce to 65% at age 65 and 50% at age 70. Benefit is based on annual earnings as of coverage start date.

Voluntary Life and AD&D Insurance

In addition to the provided life insurance, you may also purchase additional life insurance coverage through One America for yourself, your spouse and your dependent children.

New hires can elect up to the Guarantee Issue amount without Evidence of Insurability (EOI). If you are not a new hire, you can increase your coverage by the greater of $10,000 or 10% of your current election up to the Guarantee Issue without EOI. To submit EOI visit www.oneamerica.com/eoi.

Benefits reduce to 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85 and 15% at age 90.

Voluntary Life and AD&D	
Employee Benefit	Increments of $10,000 up to the lesser of 5 X Base Annual Earnings or $500,000 Guarantee Issue - $200,000
Spouse Benefit	Coverage is available in $5,000 increments up to 50% of employee's election up to $100,000 Guarantee Issue - $50,000
Child Benefit	$10,000

Employee/Spouse Monthly Rate Per $1,000	
Age	Rate
0-19	$0.040
20-24	$0.040
25-29	$0.040
30-34	$0.060
35-39	$0.070
40-44	$0.090
45-49	$0.150
50-54	$0.260
55-59	$0.420
60-64	$0.560
65-69	$0.840
70-74	$1.540
75-79	$2.320
80+	$4.220
Voluntary AD&D for all ages - $0.030	

403B Retirement

Saving for retirement is an important piece of your overall financial Wellness. Because of this, Spalding University offers robust 403(b) retirement plan through the Association of Independent Kentucky Colleges and Universities (AIKCU), where you can contribute pre-tax or Roth after-tax dollars and save for your future. Visit tiaa.org/aikcu to enroll, view contributions, or make updates to your account.

- Eligible employees may begin making contributions to their retirement plan upon hire date.
- The University will match your employee contribution up to 5% dollar for dollar.

Personalized Advice

- Receive custom insights to help optimize your investment portfolio using our online tool.

Sick Days

All full-time faculty receive 12 sick days per year (pro-rated based on hire date). A maximum of 12 days can be carried over to the next fiscal year."

Paid Holidays 2025-2026		
Independence Day: July 4, 2025	**Labor Day:** September 1, 2025	**Thanksgiving Break:** November 26-28, 2025
Holiday Break: December 24, 2025 - January 2, 2026	**Martin Luther King Jr:** January 19, 2026	**Good Friday:** April 3, 2026
Easter Monday: April 6, 2026	**Oaks Day (Derby Eve):** May 1, 2026	**Memorial Day:** May 25, 2026
Juneteenth: June 19, 2026		

Other University Benefits

Wellbeing Program

Spalding University knows that traditional approach to workplace health promotion is not enough to reach our employee's goals for overall health. We take a more holistic approach to our employee's wellbeing by focusing in on 5 key areas: career, financial, community, social and physical.

Through the Wellbeing Program, Spalding employees can participate in a host of activities right here on campus to help improve our employee's wellbeing. See Human Resources for plan details.

Weight Rooms

Spalding University's recently remodeled weight room is open, free of charge, to all faculty and staff. The hours of operation are 7:00 am—7:00 pm Monday through Saturday. The faculty and staff locker rooms are located across the hall from the weight room. For further information, please contact Lisa Bash-DeFrees at 502-873-4201 or email: lbash@spalding.edu in Athletics.

Tuition Benefits

Employee Education Benefits

Undergraduate Courses:

After the completion of one year of service, employees may receive 100% remission for up to 24 credit hours of Undergraduate courses.

Graduate Courses:

After the completion of one year of service, full-time employees who meet admission requirements and have approval of their supervisor and the University Provost, may enroll University Graduate Programs and receive a 100% tuition waiver. The Naslund-Mann (MFA) and PsyD programs are excluded from this waiver. There is no limitation to the number of credit hours to which the waiver will apply. Spouses and children of full-time employees are not eligible for a tuition waiver for graduate programs. The employee must have satisfied one year of service prior to the class start date for the waiver to apply.

Effective January 1, 2018 up to two (2) Spalding employees are permitted to enroll in each graduate program per academic year. To be considered for enrollment, employees are required to apply to the program. Upon acceptance, the Provost will review the application and select who will be admitted. The criteria for selection is twofold: (1) applicability of the graduate program to current job duties; and (2) years of service to Spalding University. The University Provost reserves the right to admit more than 2 employees into any graduate program at their discretion. If an employee resigns or is terminated while receiving tuition remission, the remission will end on the employee's last day and the employee will have the option to continue in the graduate program at their own expense.

Upon receipt of a Spalding master or doctoral degree, the employee is required to remain employed at Spalding for the number of years equivalent to the years of the graduate program. For example, a graduate of a two year program would be required to continue employment at Spalding for two years following receipt of their degree. If the employee resigns their employment during this period of time, the employee is required to remit the cost of the graduate program to the University on a pro-rated basis.

Dependent Educational Benefits

After an employee completes one year of service, their dependents who meet admission requirements are eligible for a 50% tuition waiver with an additional 10% waiver for each year of employee service over one year until reaching 100%. This benefit is for undergraduate courses only.

Other Tuition Remission Opportunities

Tuition Remission may also apply to other colleges and universities participating in the Coalition for Independent Colleges Tuition Benefits (CIC) http://www.cic.edu/member-services/tuition-exchange-program Please contact Human Resources for more details.

Your ComPsych® GuidanceResources® Program

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Free Online Will Preparation

Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

ONEAMERICA®

OneAmerica® is the marketing name for companies of OneAmerica. OneAmerica markets ComPsych services. ComPsych is not an affiliate of the companies of OneAmerica.

Peace of Mind When Traveling

Travel assistance

Emergencies happen, but help is now only a phone call or email away. On Call International® offers a suite of services to help you in your time of need — from small inconveniences like losing your luggage to life-threatening situations — all delivered with a caring, human touch.

Find comfort in knowing you and your loved ones are protected by the Travel Assistance benefit when traveling more than 100 miles from home for business or leisure. The Travel Assistance benefit protects you when covered under a OneAmerica® company group life insurance policy. It also extends coverage to your spouse, domestic partner and children (under 21 or 25 and living at home as a full-time student) even when they are traveling without you. The Travel Assistance benefit requires no additional premium; however, exclusions do apply.

Medical assistance and transportation services

Pre-trip plan to provide up-to-date information regarding required vaccinations, health risks, travel restrictions and weather conditions.

Medical monitoring and review of documentation utilizing professional case managers and medical professionals to ensure appropriate care is received.

24-hour nurse help line to provide clinical assessment, education and general health information.

Replacement of prescriptions and eyeglasses that have been lost or stolen by consulting with the prescribing provider to transfer prescription to or arranging an appointment with a local provider.

Medical, behavioral or mental health, dental and pharmacy referrals to assist in finding care providers and medical facilities.

Coordination of benefits by requesting health information from the participant and attempting to coordinate benefits during an active travel assistance case.

Emergency medical evacuation to arrange and coordinate air and/or ground transportation and medical care during transportation to the nearest hospital where appropriate care is available.

Medical repatriation to arrange the transport of the participant with a qualified medical attendant, if medically necessary, to their residence or home hospital.

Return of remains to arrange the transportation of a participant's remains to their home in the event of their death while traveling.

24-hour travel assistance

Travel Assistance is made available through OneAmerica® by an agreement with On Call International®

1-800-575-5014 (US/Canada)

1-603-898-9172 (call collect from other locations)

Email: **mail@oncallinternational.com**

Compliance Notices

AssuredPartners

PLAN ADMINISTRATOR / HR CONTACT INFORMATION

Plan Administrator/HR Contact: Stephen Jordan
Plan Administrator/HR Contact Phone Number: 502-873-4225
Plan Administrator/HR Contact Email: sjordan@spalding.edu

IMPORTANT! If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please see the Notice of Creditable/Non-Creditable Coverage on Page 27 for important information!

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322 Fax:1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO –Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Ctr:
1-800-221-3943/ State Relay 711 CHP+
https://www.colorado.gov/pacific/hcpf/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: 1-855-692-6422

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

GEORGIA – Medicaid
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-partyliability/childrens-health-insuranceprogram-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Phone: 1-877-438-4479
Family and Social Services Administration
Phone:1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP_PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.Medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

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

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
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)

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

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

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid and CHIP
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
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)

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

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

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

TEXAS - Medicaid
Website: Health Insurance Premium Payment (HIPP)Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
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
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

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

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
https://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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

To see if any other states have added a premium assistance program since July 31, 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 and Medicaid
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext.61565

Notice of HIPAA Special Enrollment Rights

You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents (including your spouse) under certain circumstances, as described below.

If you decline enrollment for yourself or for an eligible dependent while other health insurance or group health plan coverage is in effect, 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).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or coverage under a state children's health insurance program, or when you and/or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan. However, you must request enrollment **within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program or **within 60 days** after the determination of eligibility for assistance.

If you would like more information on your special enrollment rights or need to request enrollment, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to health care 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.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

If you would like more information on WHCRA benefits, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note, more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

If you would like more information on the NMHPA, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Notice of Patient Protections and Selection of Providers

Designation of a Primary Care Provider (PCP) - If the health plan in which you are enrolled (or enrolling) requires the designation of a primary care provider (or "PCP"), you have the right to designate any PCP who participates in the plan's provider network and who is available to accept you or your family members. For children, you may designate a participating pediatrician as the PCP. For information on how to select a PCP, and for a list of the participating primary care providers, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Direct Access to Obstetrics and/or Gynecological Specialists - If the health plan in which you are enrolled (or enrolling) requires referrals to see specialists, you do not need prior authorization to obtain access to obstetrical and/or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. Please note, however, the health care professional, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Notice of Availability of Plan's Notice of Privacy Practices (NPP)

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your health information that the plan creates, requests, or is created on the plan's behalf, called Protected Health Information ("PHI") and to provide you, as a participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information. The privacy policies are described in more detail in the plan's Notice of Privacy Practices (NPP). The NPP describes how medical information about you may be used and/or disclosed and how you can get access to this information. If you would like a copy of the Notice of Privacy Practices, please contact Human Resources and/or the Plan Administrator, see page see the Notices Title page for contact information. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Continuation of Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employers who employ 20 or more employees are subject to the continuation provisions of COBRA.

COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end because of certain "qualifying events", such as termination of employment (for reasons other than gross misconduct), reduction in hours, divorce, legal separation, death, or a child ceasing to meet the definition of dependent under the group health plan 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 group health plan coverage is lost because of a COBRA qualifying event. Upon termination, or other COBRA qualifying event, all qualified beneficiaries will receive COBRA election information.

In addition, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual health 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.

After your initial enrollment in our group health plan(s), you, and any other members of your family who you also enroll in coverage, will receive a COBRA Initial (or General) Notice that will explain your COBRA rights and responsibilities. Please read it carefully.

For more information about your rights and obligations, you should review the plan's Summary Plan Description or contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Coverage While on FMLA Leave

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

If you take Family and Medical Leave Act (FMLA) leave, we will continue to maintain your coverage to the extent required by the FMLA (that is, we will continue to pay our share of the premiums to the extent that you opt to continue coverage). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your share of the health insurance premiums), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as otherwise required by the FMLA. Under special rules that apply if an employee does not return to work at the end of an FMLA leave, you may be entitled to elect COBRA even if you were not covered under the plan during the leave. Contact Human Resources and/or the Plan Administrator for more information about your rights and responsibilities under the FMLA, see the Notices Title page for contact information.

Continuation of Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For more information about your rights under USERRA, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask employees NOT to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Creditable Coverage for the 2024-2025 Plan Year

We have determined that the prescription drug coverage provided under the Spalding University Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or else without "creditable" prescription drug coverage from another source (such as ours).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce payment in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Human Resources and/or the Plan Administrator, see Notices Title page for contact information.

Marketplace (Exchange) Notice PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace (the "Exchange") and health coverage offered through your employment.

What is the Health Insurance Marketplace (Exchange)?

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 in your geographic area.

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 My Employer's Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5%[1]of your annual household income for the year, OR if the coverage your employer provides does not meet the "Minimum Value (MV) Standard" set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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 each Nov. 1 and continues through at least Dec. 15. Certain events may also trigger a midyear Special Enrollment Period, such as when getting married, having a baby, or adopting a child, or losing eligibility for other health coverage, including Medicaid and CHIP. 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.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Human Resources and/or the Plan Administrator, see Notices Title page for contact information. The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** to find more information.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop

[2] An employer-sponsored health plan meets the "Minimum Value (MV) 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 and meets other requirements.

PART B: General Information

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number
Spalding University	61-0444780
5. Employer address	**6. Employer phone number**
845 S. Third Street	(502) 585-9911

7. City	8. State	9. Zip code
Louisville	KY	40203

10. Who can we contact about employee health coverage at this job?	
Stephen Jordan	
11. Phone number (if different from above)	**12. Email address**
(502) 873-4225	sjordan@spalding.edu

Here is some basic information about health coverage we offer:

As your employer, we offer a health plan to:

Full time employees working at least 30 hours per week who have satisfied the necessary waiting period.

With respect to dependents:

Legal spouse and dependent children to age 26.

[X] If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable for most or all full-time employees under one of the §4980H Affordability Safe Harbors.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.