2027



ILLINOIS WESLEYAN UNIVERSITY

Employee Benefits Guide

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CONTACT INFORMATION

If you have any questions regarding your benefits, please contact your IWU Benefits Team.

MEDICAL INSURANCE
Blue Cross Blue Shield
www.bcbsil.com
800-548-1686

DENTAL INSURANCE
The Principal
www.principal.com
800-548-1686

VISION INSURANCE
Blue Cross Blue Shield/Eye Med
https://member.eyemedvisioncare.com/bcbsil/en
855-362-5539

LIFE/AD&D & DISABILITY INSURANCE
The Standard
www.login.standard.com
888-937-4783

IWU BENEFITS TEAM
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309-556-3971

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Want to learn more?
Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.

2027 Benefits Overview

Welcome to the

2027 BENEFITS OPEN ENROLLMENT

It's that time of year again! Illinois Wesleyan University's annual insurance open enrollment period is about to begin.

Illinois Wesleyan University strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of your benefits and have provided the following Benefits Choice/Open Enrollment Guide for you to review. In addition to general benefit information, you will find links to benefit websites and plan summaries. If you experience any access or platform issues with the Online Benefit Enrollment Platform (CBIZ Enroll), please reach out to Kat Jiardina at kjiardin@iwu.edu or 309-556-3971.

Elections or changes you make during the Open Enrollment period will become effective January 1, 2027.

How to enroll in the IWU health plan?

You will need to complete a your enrollment for the following situations:

- If you are NOT currently enrolled and want to enroll in the BCBS medical plan, Principal dental plan or BCBS/EyeMed vision plan for 2027
- If you want to change your BCBS medical plan option
- If you want to terminate coverage in the BCBS medical plan, Principal dental plan or BCBS/EyeMed vision plan
- If you want to add or terminate dependent(s) to your coverage

As you review this guide, make sure to note the following:

- **Open Enrollment begins Monday, November 9**
- **Benefit Enrollment and Changes are due no later than Friday, November 20**
- **Flexible Spending Account (FSA) and Health Savings Account (HSA) forms are due Friday, November 20**. Current elections DO NOT carry forward for FSA and HSA. To continue participation in the new year, you must make a new election during open enrollment.
- **Changes to plans and premiums** are effective January 1, 2027
- As always, we value you as a member of the Illinois Wesleyan community and we look forward to a healthy and safe year.

REMEMBER!

Unless you experience a qualifying event, Open Enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

Online Benefit Enrollment Platform (CBIZ Enroll)

When you are ready to enroll in the Illinois Wesleyan University provided benefit plans, you may logon to your personal employee benefit website. This website includes information about your benefit plans, allowing you to enroll quickly and easily, and access your benefit information throughout the year.

1. Go to: iwu.cbizenroll.com
2. Enter your username: **first letter of first name + First 4 letters of last name + 001**
3. Enter your password: **Date of Birth formatted MMDDYYYY**
   After the initial logon, you will be asked to change your password. (In order to ensure that your account is secure, your new password must meet minimum complexity requirements. The longer your password is and the more different characters and symbols you use, the more likely it will be to meet the requirements.)
4. On the Welcome page you will see which benefits you can enroll in by selecting Guided Enrollment.

Qualifying Life Events: Many of the elections you make, including declining enrollment for yourself, your spouse, and/or other dependents, will not be able to be changed until your next open enrollment period, unless you experience a qualifying life event (such as marriage, divorce, birth/adoption, death or loss of other coverage). If you experience a qualifying life event, you may be able change your coverage or enroll in coverage, provided that you request enrollment changes within 30 days of the event or 30 days of your other coverage ending, and the changes are approved. To make a change in your coverage due to a Qualifying Event, please follow these steps:

1. Logon to the employee benefit website: iwu.cbizenroll.com
2. Select Qualifying Event under the Benefits menu.
3. Select the appropriate type of qualifying life event.
4. Make the appropriate changes to your benefits (adding/removing/changing coverage).
5. Upload the required documentation or send it to your Benefits Team at Human Resources.

Please note that IRS regulations and insurance carriers determine which benefits cannot be changed without a qualifying event. The type of qualifying life event you experience determines what changes to your coverage you can make.

Help and Website Tips: For helpful information on your benefits and how to use the employee benefit website:

- Go to View/Edit Enrollment on the welcome page.
- Go to any of the Helpful Links on the welcome page.

If you lose your username or password, use the links under the Login menu to reset your account. If this does not work for you or you have any questions, please contact your Company HR/Benefit Department.



Medical Insurance

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?
You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

Will I receive a new Medical ID card?
You will receive an ID card in the mail if you are eligible medical coverage.

Does the deductible run on a calendar year or policy year basis?
A calendar year basis.

How long can I cover my dependent children?
Dependent children are eligible until the end of the month in which they turn age 26.

What should I do if myself or a dependent has other coverage besides the BCBSIL plan?
Complete the Coordination of Benefits (COB) form with BCBSIL . See benefit library for more details.

I just got hired. When will my benefits become effective?
Your medical insurance benefits will begin on the 1st of the month following date of hire/eligibility date for regular full-time employees.

Can premiums be withheld from paychecks on a pre-tax basis? Yes, it can for medical, dental and vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Can elections be changed during the plan year?
Your election can only be changed if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Where can all plan details be found?
All plans are detailed in the BCBSIL 2027 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to the certificate.

What is an out-of-pocket maximum?
This includes all cost-sharing: deductible, coinsurance and copays.

TYPES OF DEDUCTIBLES

NON-EMBEDDED DEDUCTIBLE → Entire family must meet the family deductible before the health plan starts to pay →
- Example: $1,500 Single Deductible, $3,000 Family Deductible
- 5 family members are enrolled in this contract
- 1 or a combination of multiple members of the family must hit the $3,000 deductible before the plan starts paying for that entire family

EMBEDDED DEDUCTIBLE → A single family member must meet their individual deductible before the health plan starts to pay →
- Example: $1,500 Single Deductible, $3,000 Family Deductible
- 5 family members are enrolled in this contract
- 1 family member must meet their $1,500 deductible before the plan starts paying for that individual, this will count towards the family deductible of $3,000

MEDICAL INSURANCE

Blue Cross-Blue Shield of Illinois

The following changes to the IWU medical plans will take effect January 1, 2027:

- The medical plans will incur a premium increase of 15% for the PPO plan and a decrease of 7.5% to the HDHP.

2027 Monthly Premiums	Employee Premium	IWU Contribution	Total
HDHP Plan			
Employee Only	**$72.00**	$1,154.04	$1,226.04
Employee & Spouse	**$561.00**	$1,891.08	$2,452.08
Employee & Child(ren)	**$512.00**	$1,674.88	$2,186.88
Family	**$878.00**	$2,938.84	$3,816.84
PPO Plan			
Employee Only	**$95.00**	$1,233.04	$1,328.04
Employee & Spouse	**$637.00**	$2,019.08	$2,656.08
Employee & Child(ren)	**$577.00**	$1,813.88	$2,390.88
Family	**$983.00**	$3.139.84	$4,122.84

*** Again in 2027, Illinois Wesleyan will contribute $500 into an HSA for employees choosing Employee Only coverage on the HDHP medical plan ($1000 for Employee plus dependent(s) coverage).**

If you need assistance making this decision, please see Pages 9-10 of this document. You can also schedule a meeting with HR by contacting Kat kjiardin@iwu.edu.

While both medical plans give you the option of using out-of- network providers, remember that you can save money by using in-network providers because Blue Cross Blue Shield has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for a higher deductible which is not credited to your in-network deductible.

2027 Medical Plan Designs (In-Network)

	HDHP Plan	PPO Plan
Deductible:		
Individual	**$3500**	$1700
Family	**$7000**	$3400
Member Coinsurance:	20%	20%
Out-of-Pocket Maximum:		
Individual	**$7000**	$3400
Family	**$14000**	$6800
Office Visit Copays:		
Primary Care	Deductible & Coinsurance	$30
Specialist	Deductible & Coinsurance	$50
Urgent Care	Deductible & Coinsurance	$30
Virtual Visits	$48 applied to deductible	$15
Preventative Care	Covered at 100%	Covered at 100%
Hospital Services:		
Emergency Room	Deductible & Coinsurance	**$350 (waived if admitted)**
In-Patient	Deductible & Coinsurance	$200
Out-Patient	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drug Copays:		
Generic	Deductible & Coinsurance	$20
Formulary Brand	Deductible & Coinsurance	$40
Non-Formulary Brand	Deductible & Coinsurance	$60

BlueCross BlueShield of Illinois

Please note: IWU does not offer COBRA continuation benefits when employment ends.

* Notes specific to the HDHP:
(1) If you have dependents covered, the individual deductible and out-of-pocket amounts do apply. If a single family member meets their individual deductible the plan pays even if the family deductible has not been met. (2) Routine eye exams are not included on the IRS-approved preventative services list. They will not be covered at 100% on the HDHP plan.

Medical Insurance

The BCBS Medical Plans include many additional benefits available to members, including:

- **Blue Access for Members** portal at www.bcbsil.com – Gives you the ability to check the status of your claims, view/save Explanation of Benefits forms (EOBs), check coverage details and Rx information, search for an in-network provider and request a new ID card.
- **BCBSIL phone app** – Gives you the same capabilities as Blue Access for Members, plus a Virtual ID card.
- **Virtual Visits** – With a virtual visit, you can meet and consult with a covered MD Live provider in the privacy of your own home. These providers can also write prescriptions and have them sent directly to your nearest pharmacy. Watch this YouTube video about Virtual Visits and sign up at www.MDLIVE.com.
- **Member Rewards** – Use Member Rewards to help find a lower-cost, quality provider for a recommended medical procedure and **receive a reward**.

  1) Select the provider
  2) Have the procedure or service done
  3) The claim is paid and so are you! You'll receive a reward check in the mail at home 6-8 weeks following the procedure.

  Search for providers offering Member Rewards online, through the BCBS phone app or by calling BCBS Member Services at (800) 548-1686.

BlueCross BlueShield of Illinois

Get the most out of your insurance by using **in-network providers.**



BCBS Pharmacy Benefits include:

- **Split / Fill** - This program applies to expensive medications that members may be unable to tolerate (such as oral oncology drugs). It is not uncommon for a member to try several different medications before finding one that works well.
  1) The member is given a partial amount of the medication at a prorated copay.
     - If they tolerate the drug, they pick up the remainder of the prescription and pay the remainder of the copay.
     - If they do not tolerate it well, they try another alternative prescription.
  2) Less money is spent on medications that do not work; this is a savings to the member and the University.
- **Flex Access.** This is a program that allows access to copay assistance programs (discounts or coupons on select prescription drugs offered by drug companies). This program is a cost savings to the member and the University.
  1) Over 80% of specialty drugs participate in the copay assistance program.
  2) The member's copay is reduced at the time the prescription is filled.

Which Medical Plan is right for me?

Next Steps:

- Complete the online enrollment process to indicate your enrollment in the
- HDHP or PPO plan
- Review the information below about the HDHP and PPO plans.
- If you would like to schedule a meeting with HR, contact Kat kjiardin@iwu.edu

Similarities between the HDHP and PPO plans:

- Coverage of visits and services is the same on both plans however, your responsibility may be different (see below).
- The BCBS network of providers/facilities is the same on both plans.
- The BCBS network discounts are the same on both plans.

Differences between the HDHP and PPO plans:

HDHP Plan Option:

1. The HDHP plan is a *high-deductible health plan*:
    - You are responsible for paying all claims up to the deductible before there is any coinsurance paid by BCBS (except for most preventative care and virtual visits).
    - If you have dependents covered on the HDHP plan, the individual deductible and out-of-pocket (OOP) amounts do apply. If a single family member meets their individual deductible the plan pays even if the family deductible has not been met.

1. For Employee Only coverage, the HDHP plan has a slightly lower premium than the PPO plan. Dependent covered plans have higher premiums on the HDHP plan.

2. For those covered by the HDHP plan, IWU will make contributions to a *Health Savings Account (HSA)* at HSA Bank (see pages 15-16).
    - The contribution is $500/year for Employee Only coverage ($1000/year for Employee plus Dependent(s) coverage).
    - You can also contribute to your HSA by way of pre-tax payroll deductions.
    - These HSA funds can be used to reimburse you or pay for IRS-approved health expenses.
    - Unlike a Flexible Spending Account (FSA), these funds are not forfeited at the end of each year. The balance in the HSA account is yours, even if you leave IWU.

PPO Plan Option:

1. The PPO plan is a *preferred-provider health plan*:
    - You are responsible for paying a copay for office visits and prescriptions.
    - You are responsible for paying claims up to the deductible for out-patient services (x-rays, lab work, surgery).
    - If you have dependents covered on the PPO plan, the individual deductible and OOP amounts apply to the first member who meets those limits. The additional family members' claims make up the difference between the individual and family deductible and OOP.

2. For Employee Only coverage, the PPO plan has a slightly higher premium than the PPO plan. Dependent covered plans have lower premiums on the PPO plan.

3. For those covered by the PPO plan, you can set up a *Health Care Flexible Savings Account (FSA)* at Chard Snyder (see page 14).
    - You can contribute to your FSA by way of pre-tax payroll deductions.
    - Your FSA funds can be used to reimburse/pay for IRS-approved health expenses.
    - Unused balances in a Flexible Spending Account (FSA) are forfeited at the end of each year. IWU offers a grace-period. You have until 3/15 to incur expenses and until 4/30 to submit requests for reimbursement of your prior year balance.

Care Options & When to Use Them

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the BCBS website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting the BCBS website at bcbsil.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary / preventive care or non-urgent treatment, we recommend going to your doctor's office.

Your doctor knows you and your health history and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

VIRTUAL VISITS

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems
- UTI

MD Live or a "virtual visit," lets you talk to a doctor anytime, anywhere from your mobile device or computer — no appointment necessary.

Blue Cross Blue Shield partners with MD Live to bring you care from the comfort and convenience of your home or wherever you are.

URGENT CARE

- Sprains & Strains
- Small cuts
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office.

Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) that you believe may result in serious injury or death without immediate medical care.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

Primary Care vs. Urgent Care vs. ER

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

DENTAL INSURANCE

The Principal

Dental Coverage will remain the same for plan year 2027. There will be no change to the dental premiums for 2027 (see chart below).

IWU's optional dental insurance helps pay for your dental care. Studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

In-Network and Out-of-Network Coverage are the same.
However, depending on your dentist, you may be responsible for costs above Usual and Customary standards. Balance billing may also be possible.

Type of Service	Dental Plan Coverage
Preventative Services	Covered at 100% • Exams, cleanings (two times per calendar year) • X-rays (coverage may be limited based on age of patient and type of service)
Annual Deductible	$50 for individual and $100 for family (applies to Basic and Major Services)
Basic Services	Covered at 80% after the deductible * Fillings, root canals, oral surgery (including wisdom teeth)
Major Services	Covered at 50% after the deductible * Caps, crowns, bridges
Annual Maximum	$1,000 maximum allowed per individual on an annual basis for Preventative, Basic and Major Services
Orthodontic Services	Covered at 50% with a lifetime maximum of $1,000 for dependent children under age 19

2027 Monthly Premiums	Employee Premium	IWU Contribution	Total
Employee Only	$12.00	$33.00	$45.00
Employee & Child(ren)	$29.00	$71.00	$100.00
Employee & Spouse	$29.00	$71.00	$100.00
Family	$33.00	$78.00	$111.00

VISION INSURANCE

BCBS/EyeMed

Illinois Wesleyan's optional vision insurance coverage and premiums remain the same in 2027 (see chart below).

This coverage entitles you to specific eye care benefits including routine eye exams and other procedures. It also provides an allowance for the purchase of eyeglasses and contact lenses.

To find a BCBSIL/Eye Med Vision Provider in your area, visit the website at https://member.eyemedvisioncare.com/bcbsil/en

- Type in your ZIP Code, then under the drop down "Doctor Network" select "Choice" then click the green "Search" button
- Choose a provider from the list, or narrow your search further using the left-hand side of the page to narrow results by Distance, Frame Brand, Language, Services, Products, etc.

Type of Service	Dental Plan Coverage
Preventative Services	Routine Eye Exams – $10 copay (once every 12 months) If you have the IWU BCBS PPO medical plan, a routine annual eye exam is covered by your medical plan at 100%. If you have the IWU BCBS HDHP medical plan, a routine annual eye exam is NOT covered by your medical plan (due to IRS rules governing high-deductible health plans).
Basic Services	Frames (once every 24 months) – up to $130 allowance Lenses or Contacts (once every 12 months) – See Summary of Vision Benefits for details on coverage.
Additional Benefits	Discounts on additional pairs of glasses and non-prescription sunglasses. Discounts on Lasik vision correction.

2027 Monthly Premiums	Employee Premium
Employee Only	$ 7.52
Employee & Child(ren)	$15.06
Employee & Spouse	$14.30
Family	$22.14

EAP / Mental Health Resources

Mental health includes your emotional, psychological, and social well-being. It can affect how you think, feel, and act. It also determines how you handle stress, relate to others, and make healthy life choices. Illinois Wesleyan University understands the importance of your mental health and offers the following additional resources:



Employee Assistance Program (EAP)

The EAP benefit provides counseling and consultation services.

- Services are available to help employees resolve personal difficulties that may be affecting their quality of life or job performance. Eligible employees and their immediate family members receive unlimited telephonic counseling and four face-to-face counseling sessions per issue per academic year.
    - For confidential assistance, call (800) 252-4555 or (800) 225-2527.
    - For face-to-face counseling sessions, mention your medical plan coverage to ensure you visit an in-network provider.
- The EAP website also offers many other benefit opportunities including financial counseling, legal advice, life coaching and much more.

The Standard EAP

The Standard's Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family. If you are experiencing stress, having financial difficulties, struggling at work or home, please call 888 293-6948 to speak with someone 24/7. Available online at: healthadvocate.com/standard3

BCBS Medical Plans

The BCBS Medical Plans offer coverage for mental health counseling beyond that of the EAP. Visits are covered at the primary care copay amount.

Flexible Spending Accounts (FSA)

FLEXIBLE SPENDING ACCOUNTS

Chard Snyder (formerly BPC)

A Flexible Spending Account (FSA) allows you to pay for predictable, eligible health care expenses or expenses related to the care of a dependent child or adult with pre-tax dollars, lowering your taxable income and saving you money.

- To participate, you must enroll each year. Your current year enrollment will not continue into next year.

HEALTH CARE Flexible Spending Accounts (for those covered by the PPO Medical Plan)

This pre-tax account enables you to be reimbursed for medical, dental, vision and prescription drug expenses for you and your dependent family members, whether or not you are covered by the IWU health plan. The total amount of your annual election is available to you up front, reducing your chance of incurring a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account is forfeited following the grace period after the end of the plan year (expenses must be incurred by March 15 of one year to use remaining funds in the previous year).

Examples of Eligible Health Care Expenses

- Coinsurance
- Copayments
- Crutches
- Deductibles
- Dental expenses, including orthodontia
- Diagnostic expenses
- Hearing devices, including batteries
- Hospital bills
- Laboratory fees
- Orthopedic shoes
- Prescription drugs
- Prescribed vitamin supplements (medically necessary)
- Vision expenses (glasses, contacts)

How Health Care Flexible Spending Accounts Work

When you have out-of-pocket expenses (such as copays and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Chard Snyder. Reimbursement is issued to you through direct deposit into your bank account or by check.

2027 FSA Maximum Contributions

Health Care Flexible Spending account	$3,500
Dependent Care Expense account	$7,500

DEPENDENT CARE Flex Accounts

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses.

- An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441 (Credit for Child/Dependent Care Expenses). Children must be under age 13.
- Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes).

Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a childcare tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family.

Contact Information:

Obtain information about your Flex account by logging on to **www.chard-snyder.com** or by calling Customer Service at (800) 982-7715.

Upload claims for reimbursement online or mail to:
Chard Snyder, PO Box 2924, Fargo ND 58108-2924.

At **www.chard-Snyder.com** you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms



What Is a Flexible Spending Account?

Health Savings Account (HSA)

HEALTH SAVINGS ACCOUNTS

HSA Bank (for those covered by the HDHP Medical Plan)

Health Savings Accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany the IWU HDHP medical plan option (a qualified high-deductible health plan - QHDHP). QHDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

- To participate, you must enroll each year. Your current year enrollment will not continue into next year.

What is an HSA?

An HSA is a savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents.

Your HSA can also be an Investment Opportunity.

Depending upon your HSA balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

HSA funds can be used for your family.

Your HSA doesn't just benefit you. You can use the funds for your spouse and tax dependents for their eligible expenses,
too — even if they're not covered by your medical plan.

Your funds can carry over and even grow over time.

The money in your HSA always belongs to you. Even if you leave IWU or you don't have many health care expenses now,
your funds will carry over from year to year and will always be there if you need them in the future — even after retirement.

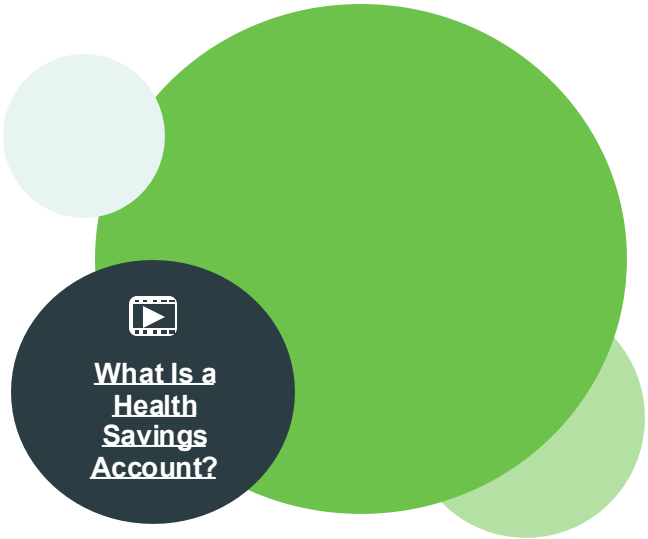
IWU contributes to your HSA.

IWU will contribute $500 into the HSA account for employees enrolled in Employee Only coverage with the HDHP BCBS plan ($1,000 for Employee plus Dependent(s) coverage).

2027 HSA Maximum Contributions

* These maximums include the IWU contribution.

Employee Only Coverage	$4,500
Employee plus Dependent(s) Coverage	$9,000
If you are 55 or older, additional contribution	$1,000



Health Savings Account (HSA)

HEALTH SAVINGS ACCOUNTS
HSA Bank

You can use HSA funds for IRS-approved items such as:

- Doctor's office visits
- Dental services, including orthodontia
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Prescription drugs and some over-the-counter medications
- (such as allergy medicine, cold and flu, pain relievers and feminine hygiene)
- Physical therapy, speech therapy and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at HSA Bank (https://hsabank.com/Learning-Center/IRS-qualified-medical-expenses

Important Information:

Every time you use your HSA Bank debit card, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

What are the HSA rules?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA (i.e. childcare flex account).
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, such as your spouse's employer, unless that secondary coverage is also a QHDHP.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved expenses/services based on IRS Publication 502.

Frequently Asked Questions

Q. What will I pay at the pharmacy with the HSA qualified plan options?
You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

Q. What will I pay at the physician's office with the HSA qualified plan?
You'll provide your ID card at the time of your visit and the physician's office will submit the claim Blue Cross Blue Shield You will not owe anything at the time of your visit. Later you'll receive an Explanation of Benefits (EOB) from Blue Cross Blue Shield IL that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

Q. Where can I get a copy of an EOB?
You can access all your EOB information, as well as obtain other important information, by logging on to https://www.bcbsil.com/

LIFE INSURANCE / AD&D and DISABILITY
The Standard

BASIC LIFE INSURANCE / AD&D

Illinois Wesleyan provides eligible employees with group life and accidental death and dismemberment (AD&D) insurance. The life insurance benefit is 1.5 times your salary.

IWU pays for the full cost of the life insurance benefit—you are not responsible for paying any monthly premiums.

The Standard life insurance policy also provides access to Travel Assist. This is a program offering medical assistance when you are traveling 100 miles from home or internationally for business or pleasure.

Reminder: Please update your beneficiaries in the enrollment portal.



SHORT-TERM and LONG-TERM DISABILITY

Illinois Wesleyan provides full-time employees with short-term and long-term disability income benefits. Without disability coverage, you and your family might struggle to get by if you miss work due to an injury or illness.

We want to do everything we can to protect you and your family. That's why **IWU pays for the full cost** of short-term and long-term disability insurance—you are not responsible for paying any monthly premiums.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, you are not eligible to receive short-term disability benefits if you are receiving worker's compensation benefits.

SHORT-TERM DISABILITY INSURANCE
IWU pays 100% of the premium cost.

The plan benefit is 70% of basic weekly earnings up to a maximum of $2,000 per week. Benefits begin after the 31st day of continuous disability for an accident or illness. Benefits can continue up to 22 weeks.

LONG-TERM DISABILITY INSURANCE
IWU pays 100% of the premium cost.

The plan benefit is 60% of basic monthly earnings up to a maximum of $12,000 per month. The benefits begin after six months of continuous disability. Benefits can continue up to age 65.

DID YOU KNOW? Illinois Wesleyan University provides Life and Disability coverage ***AT NO CHARGE***.

TRAVEL ASSISTANCE PROGRAM

What is it?

Travel Assistance is available through group insurance products provided by Standard Insurance Company. The service is provided by Assist America, Inc.

Travel Assistance can help employees, and their families prepare for trips and during critical situations while away from home. The program can assist participants with finding qualified medical provides, legal services, or with the replacement of lost credit cards and passports.

What is it not?

Travel Assistance is not travel insurance. Travel Assistance provides specific support services while traveling. Travel insurance provides monetary compensation for losses that occur while traveling.

Who is eligible?

Covered participants, which include:

- The covered employee
- The employee's dependents, including a spouse or domestic partner and dependent children, unmarried through age 25 or disabled

When can participants use this service?

For trips that are more than 100 miles from home, or in a foreign country, and for less than 180 consecutive days:

- While preparing for their trip
- While traveling on their trip

Participants MUST contact Assist America as soon as possible to use Travel Assistance.

Call 800-872-1414 within the U.S. or +1609-986-1234 outside of the US
Or use the Assist America Mobile App, available on Google Play and Apple App Store.

TheStandard®

ADDITIONAL RESOURCES FOR LIFE PARTICIPANTS

Life Services Toolkit

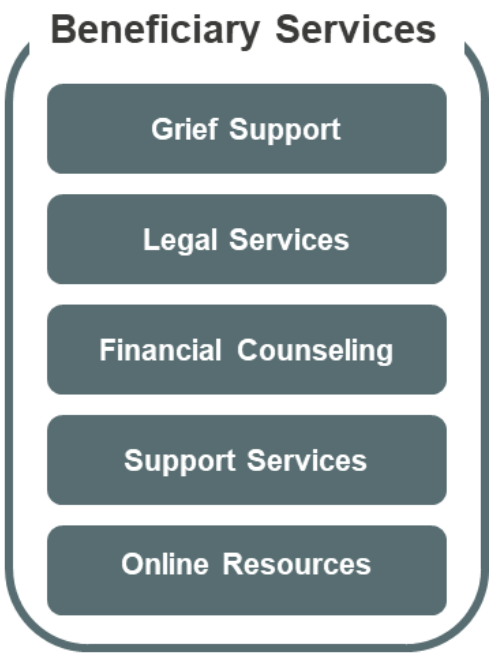
Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from The Standard does more than protect your family from financial hardship after a loss. We have partnered with Health Advocate to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.



www.Standard.com/mytoolkit
Username: assurance



www.standard.com/mytoolkit
Username: support

TheStandard®

TIAA – Retirement Accounts

Employee Plan

Employees are eligible upon hire to begin voluntary contributions (pre-tax or after-tax) into a retirement account, within limits established by the IRS.

Log into your retirement account at www.tiaa.org

Employer Plan

The IWU retirement program allows eligible employees to participate on a voluntary matching basis **after completing two years** of employment at IWU without a break in service.

- If an employee contributes at least 3%, IWU will contribute 3%.

Eligible employees are required to participate on a noncontributory basis **after completing five years** of employment at IWU.

- IWU will contribute 6%.

Contributions are applied to a retirement account owned by the participant and may be allocated into a menu of investment options.

Tips on How to Save Smart for Retirement

- Start **NOW,** keep saving and stick to it.
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investments. You can start with a $5 or 1% deduction.
- Make automatic deductions from your paycheck.
- Save regularly. Make saving for retirement a habit.
- Be realistic about investment returns. Never assume that a year or two of high market returns (or market declines) will continue indefinitely.
- Roll over retirement account money if you change jobs.

After 2 years of employment, IWU will match your 3% contribution.
After 5 years, IWU will contribute 6% to your retirement account.

Tuition Scholarships

- **Illinois Wesleyan University**
- **CIC Tuition Exchange Program**
- **Tuition Exchange**

See Tuition Scholarship Programs on the HR Webpage for details regarding eligibility, scholarships and the enrollment process for Illinois Wesleyan Admissions, CIC Tuition Exchange and Tuition Exchange programs. If you have specific questions regarding tuition, contact Carrie Kallsen in the HR Office at ckallsen@iwu.edu.

Voluntary Accidental Death & Dismemberment Insurance

This optional coverage through Zurich allows employees to secure accidental death and dismemberment insurance through the IWU group plan. An employee may enroll as an individual, or as a family with spouse and/or eligible dependents. Payment is by monthly payroll deduction. Complete the enrollment form and return to Carrie in the HR Office if you would like to enroll.



Glossary of Insurance Terms

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits, urgent care and emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

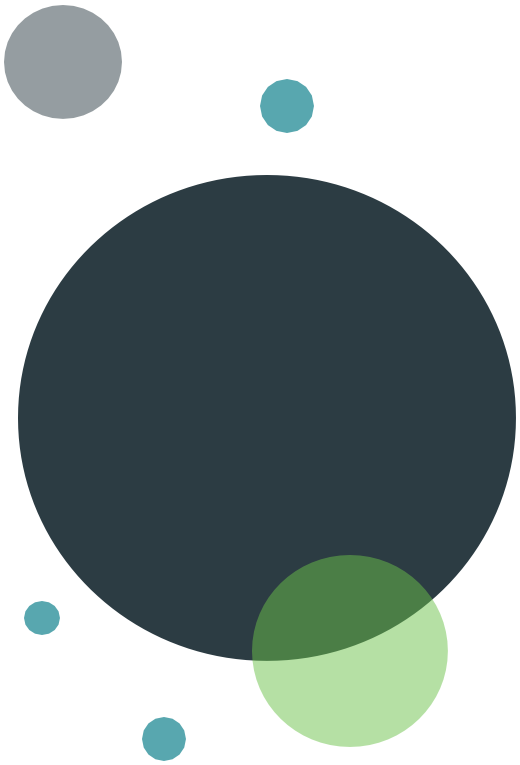
Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.
Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.



Preauthorization (also known as Prior Authorization or PA)—A process conducted by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply.

UCR (Usual, Customary and Reasonable)—The amount paid for medical or dental services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

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Important Notices – Table of Contents

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FMLA Notice

EMPLOYEE RIGHTS - THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave; * and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

FMLA Notice continued

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE (1-866-487-9243)
TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA)

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information 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 are asking that you not provide any genetic information when responding to this 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.



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, 2026. 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 (855-692-744**	**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/	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA - Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

ILLINOIS - Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA - Medicaid

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)

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

Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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	MINNESOTA - Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI - Medicaid	**MONTANA - Medicaid**
Website:http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website:http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA - Medicaid	**NEVADA - Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	**NEW JERSEY - Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/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	**NORTH CAROLINA - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA - Medicaid	**OKLAHOMA - Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON - Medicaid	**PENNSYLVANIA - Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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	SOUTH CAROLINA - Medicaid
Website: http://www.eohhs.ri.gov/ **Phone: 1-855-697-4347, or** **401-462-0311 (Direct RIte Share Line)**	**Website:** https://www.scdhhs.gov **Phone: 1-888-549-0820**
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov **Phone: 1-888-828-0059**	**Website:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **Phone: 1-800-440-0493**
UTAH – Medicaid and CHIP	**VERMONT- Medicaid**
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/	**Website:** Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **Phone: 1-800-250-8427**
VIRGINIA - Medicaid and CHIP	**WASHINGTON - Medicaid**
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**	**Website:** https://www.hca.wa.gov/ **Phone: 1-800-562-3022**

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2024 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator at (309) 556-3971.

Newborns' and Mothers' Health Protection Act Notice

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).



Privacy Practices Notice

Illinois Wesleyan University is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Illinois Wesleyan University may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact IWU Human Resources at 309-556-3971.

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.
If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.
To request special enrollment or obtain more information, contact Human Resources.

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 surprise billing or 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 may 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 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.

Your Rights and Protections against Surprise Medical Bills continued

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles 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, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

USERRA Notice

Your Rights Under USERRA

A. 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.

B. Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation
If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- 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 for up to 24 months while in the military.
- Even if you do not 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.

USERRA Notice continued

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.*

Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Human Resources at 309-556-3971.

Important Information Regarding 1095 Forms

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C by early March. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.



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