BUTLER

2024 Benefits Guide

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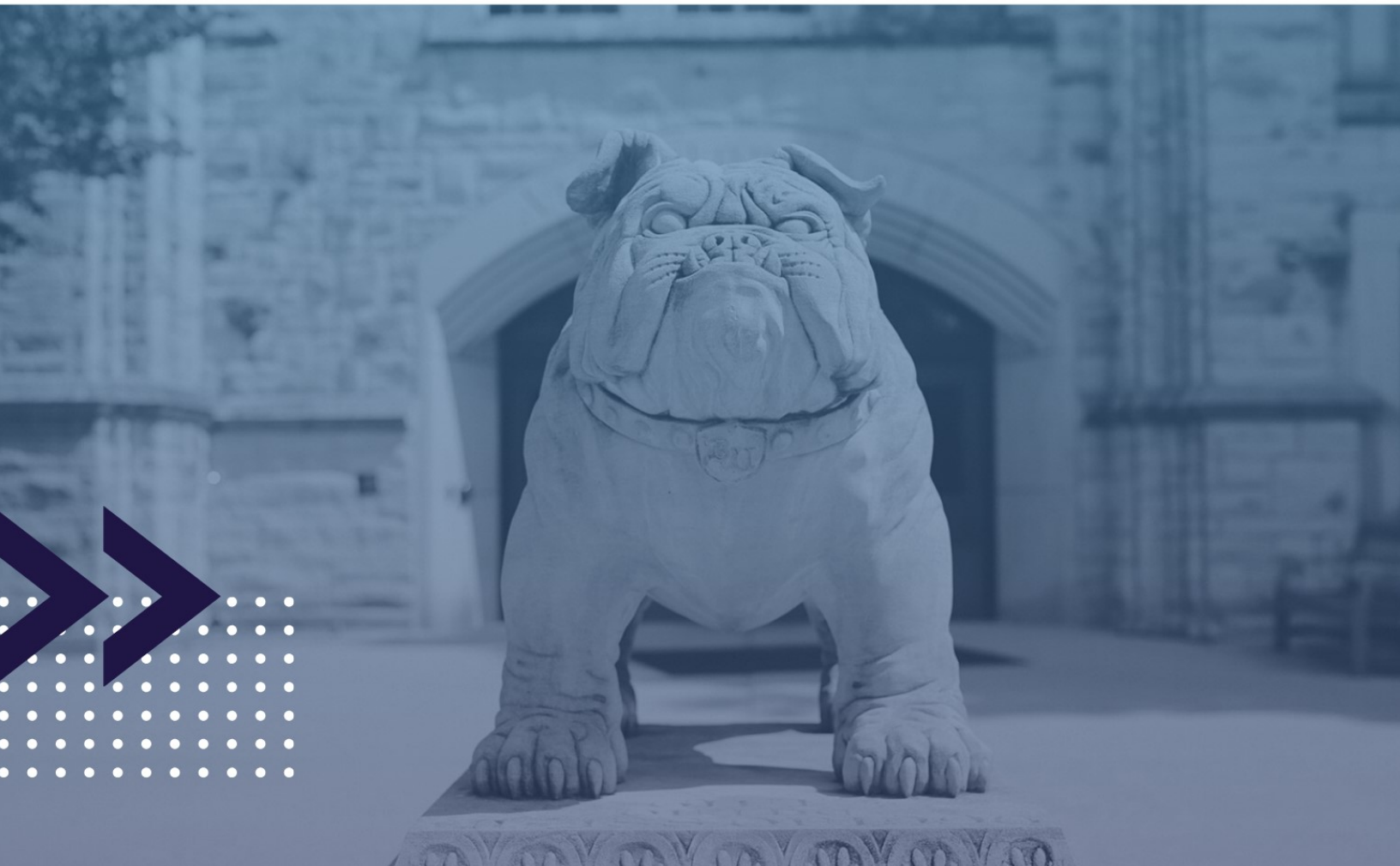


benefits

DESIGNED FOR YOU

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

Understanding your benefits and knowing how to use them is just as important as having access to them. Review this benefits guide to learn about the benefits available to you for the 2024 plan year.

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

IMPORTANT CONTACTS

Questions About	Carrier Name	Phone	Website
Medical	Anthem	See ID Card	www.anthem.com
Prescription Drugs	Magellan Rx	(800) 424-0472	www.magellanrx.com
Specialty Drug Program	PaydHealth	(877) 869-7772	
Dental	Delta Dental	(800) 524-0149	www.memberportal.com
Vision	EyeMed	(866) 939-3633	www.eyemed.com
Flexible Spending Account	WEX	(866) 451-3399	https://www.wexinc.com/solutions/benefits/participants-employees
Health Savings Account	UMB	(866) 520-4HSA	hsa.umb.com Employer Code: THA0001-143674
Basic Life and AD&D	OneAmerica	(800) 553-5318	www.oneamerica.com
Voluntary Life/AD&D	OneAmerica	(800) 553-3522	www.oneamerica.com
Short-Term Disability	OneAmerica	(800) 553-5318	www.oneamerica.com
Long-Term Disability	OneAmerica	(800) 553-5318	www.oneamerica.com
Telemedicine	LiveHealth Online	Available through the Sydney Health mobile app	
Employee Assistance Program	OneAmerica	(855) 365-4754	www.guidanceresources.com Company Web ID: ONEAMERICA6
403b (Retirement)	TIAA	(800) 842-2252	TIAA.org/butler
Benefits Central Advocacy	Hylant	(833) 856-0111	BUadvocate@hylant.com
Human Resources • HR Benefits & Wellness Office JH 052	Butler	(317) 940-9355	benefits@butler.edu – questions benefits@butler.edu – confidential information & documents

BENEFITS ELIGIBILITY

Butler University offers health and welfare programs to eligible full-time employees who work 30 or more hours per week.

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

Benefits Effective: First day of employment

DEPENDENT ELIGIBILITY

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

Benefits	Legal Spouse	Dependent Children
Medical / Rx	☑	Up to age 26
Dental	☑	Up to age 26
Vision	☑	Up to age 26

You may be asked to provide proof of dependent eligibility, such as a copy of your marriage license, birth certificate or court documents.

CHANGING YOUR BENEFITS

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

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

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

COBRA CONTINUATION COVERAGE

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

ENROLLING IN BENEFITS

ACTION ALERT

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

OPEN ENROLLMENT

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

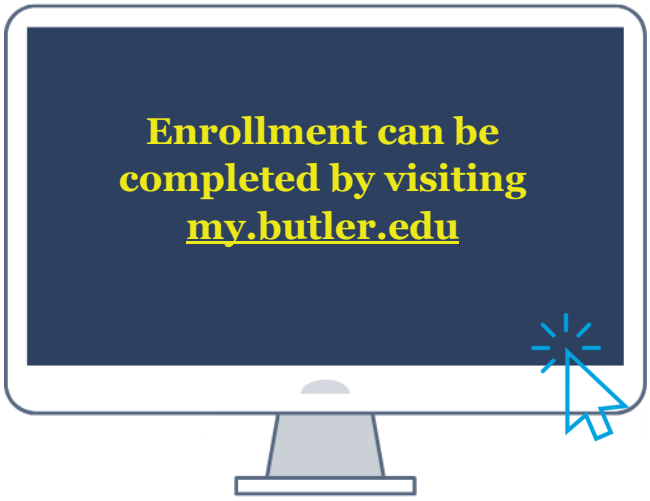
GETTING STARTED: EVALUATE

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

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

Use the websites and phone numbers in the *Important Contacts* section to see which doctors and other healthcare providers you can use under your plan choices.

HOW TO ENROLL: MAKING YOUR ELECTIONS



WHO PAYS

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

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

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

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

COST OF COVERAGE SUMMARY

	Bi-Weekly 12-Month	12-Month	Bi-Weekly 9-Month	9-Month
Medical				
PPO Plus Plan				
Employee	$92.76	$200.99	$126.94	$267.99
Employee + Spouse	$299.17	$648.21	$409.40	$864.28
Employee + Child(ren)	$183.70	$398.01	$251.37	$530.68
Employee + Family	$404.66	$876.76	$553.74	$1,169.01
PPO Core Plan				
Employee	$29.94	$64.86	$40.96	$86.48
Employee + Spouse	$150.75	$326.62	$206.28	$435.49
Employee + Child(ren)	$91.76	$198.82	$125.57	$265.09
Employee + Family	$230.43	$499.27	$315.33	$665.69
HDHP-HSA Plan				
Employee	$22.23	$48.16	$30.42	$64.21
Employee + Spouse	$120.86	$261.86	$165.39	$349.15
Employee + Child(ren)	$73.42	$159.08	$100.47	$212.11
Employee + Family	$184.83	$400.47	$252.93	$533.96
Dental				
Employee	$3.42	$7.41	$4.68	$9.88
Employee + Spouse	$13.03	$28.24	$17.84	$37.65
Employee + Child(ren)	$7.87	$17.05	$10.77	$22.73
Employee + Family	$17.14	$37.14	$23.46	$49.52
Vision				
Employee	$3.80	$8.23	$5.20	$10.97
Employee + Spouse	$6.80	$14.74	$9.31	$19.65
Employee + Child(ren)	$7.95	$17.22	$10.88	$22.96
Employee + Family	$9.84	$21.32	$13.47	$28.43

BENEFITS CENTRAL ADVOCACY PROGRAM

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

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

BILLING

PRESCRIPTION COVERAGE

CLAIMS

GENERAL BENEFIT QUESTIONS

ELIGIBILITY

ID CARDS

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

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

HOW TO CONTACT BENEFITS CENTRAL ADVOCACY LINE

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

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

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

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

MEDICAL BENEFITS OVERVIEW

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

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

PPO VS. HDHP

PPO

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

HDHP

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

THREE THINGS TO CONSIDER

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

DEDUCTIBLE

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

COPAY

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

OUT-OF-POCKET (OOP) MAX

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

COINSURANCE

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

MEDICAL BENEFITS OVERVIEW

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

Anthem

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

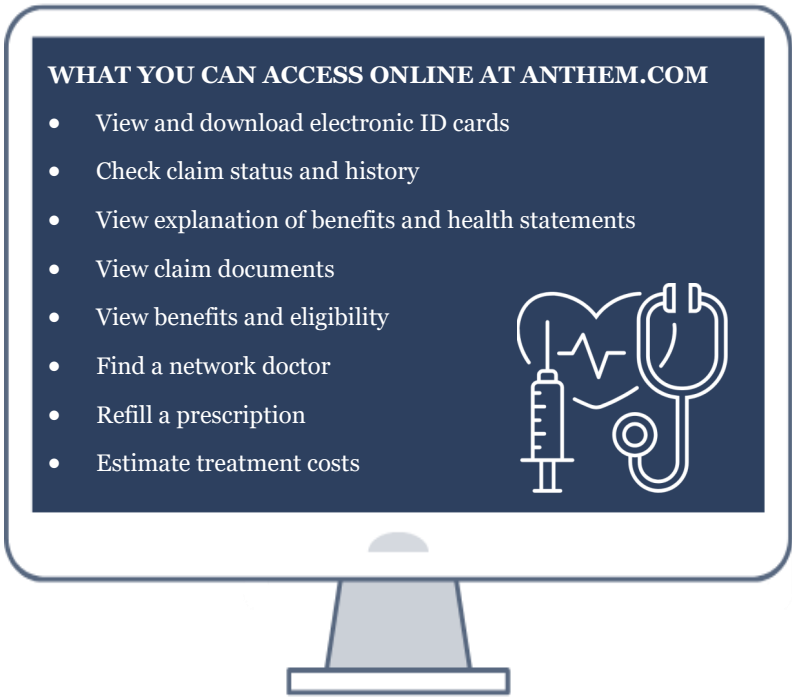
**Diagnostic services are no charge when receiving services at an in-network facility.*
See Summary Plan Document for additional details. You may also contact the plan administrator with questions regarding benefits.

ANTHEM MEMBER TOOLS

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

CREATE YOUR ANTHEM MEMBER ACCOUNT

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



SYDNEY HEALTH MOBILE APP

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

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

GET IT ON Google Play

Download on the App Store

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

TELEMEDICINE OVERVIEW

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

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

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone or online video

Prompt treatment

A network of US based, licensed doctors that can treat children at any age

No limit on consults, so take your time

Secure, personal and portable electronic health record

Conditions Treated Through LHO

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

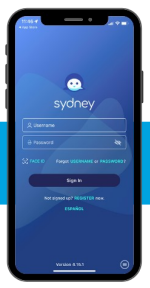
When Can I Use Live Health Online

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

COST OF CARE

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

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



RIGHT CARE. RIGHT PLACE. RIGHT TIME.

VIRTUAL CARE

<10 Minute Wait Time* | $

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

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

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

PRIMARY CARE PHYSICIAN

<30 Minute Wait Time* | $$

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

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

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

URGENT CARE

<1 Hour Wait Time* | $$$

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

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

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

EMERGENCY ROOM

~2 Hour Wait Time* | $$$$

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

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

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

This is not medical advice. Seek appropriate treatment based upon your condition. If you experience a medical emergency, visit your nearest ER or dial 911.

**Wait times are averages. You may experience a shorter or longer wait time during service.*

PHARMACY RESOURCES

MAGELLAN RX
MAGELLAN RX MEMBER

Magellan Rx is your prescription drug administrator. For any pharmacy or prescription drug questions, please contact Magellan Rx.

To get the most out of your prescription benefits, you must first create a Magellan Rx account. *Both you and your enrolled spouse must create a member account.*

REGISTER FOR A MAGELLAN RX MEMBER ACCOUNT

STEP 1. Go to www.magellanrx.com

STEP 2. Click Portal Access: Member at the top of the screen

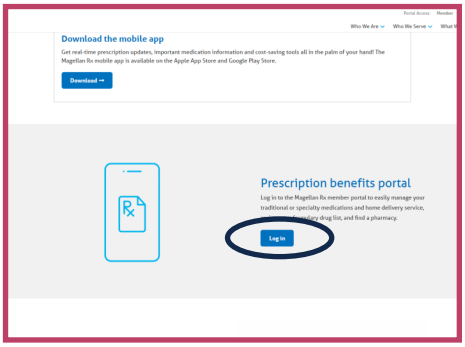
STEP 3. Click Register and fill out the registration form.

Click on the confirmation link sent to the email you registered with within 24 hours. *You will need to re-register if you do not click the link within 24 hours.*

The link will take you to the member login page. This will complete your registration.

STEP 1 & 2

STEP 3

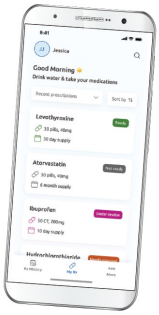


WHAT CAN I ACCESS ON THE MEMBER PORTAL?

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

DOWNLOAD THE MAGELLAN RX MOBILE APP AND HAVE PRESCRIPTION RESOURCES AT YOUR FINGERTIPS!

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



Download the app:

GET IT ON Google Play

Available on the App Store

PHARMACY RESOURCES CONTINUED

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

HOW TO GET STARTED WITH HOME DELIVERY SERVICE

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

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

Magellan Rx Pharmacy
P.O. Box 620968
Orlando, FL 32862

Follow these steps if you need a new prescription:

First, ask your doctor to write two prescriptions:

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

Next, ask your doctor to **e-prescribe** to Magellan Rx Pharmacy, LLC (Mail-ORL) or **fax** your prescription to (888) 282-1349.

HOW TO RECEIVE HOME DELIVERY REFILLS

ONLINE PORTAL

Submit your refill orders and pay online through your secure member portal.

PHONE

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

MAIL

Complete the refill section on the home delivery order form and mail it to—
Magellan Rx Pharmacy
P.O. Box 620968
Orlando, FL 32862

SPECIALTY DRUG RESOURCES

SPECIALTY MEDICATIONS—PAYDHEALTH

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

How the Program Works:

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

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

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

HOW TO GET STARTED

1

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

2

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

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

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

3

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

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

DENTAL INSURANCE

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

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

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

HOW TO FIND AN IN-NETWORK PROVIDER:

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

GET THE MOST OUT OF YOUR BENEFITS

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

DENTAL COVERAGE EXAMPLE

Below is an example of out-of-pocket expenses based on if you choose the Delta Dental PPO or Delta Dental Premier network. The Delta Dental PPO network provides higher discounts than the Delta Dental Premier network. You will not receive discounts if you visit an out-of-network provider.

HOW THE DENTAL PLAN WORKS*			
Covered Services	**Delta Dental PPO Network**	**Delta Dental Premier Network**	**Out-of-Network** **
	ADULT CLEANING		
Submitted Fee	$80	$80	$80
Maximum Allowed Fee	$54	$77	$63
Coverage Level *(Maximum of fee paid)*	100%	100%	100%
Amount Delta Dental Pays	$54	$77	$63
Amount You Pay	$0	$0	$17
	CROWN		
Submitted Fee	$1,100	$1,100	$1,100
Maximum Allowed Fee	$754	$989	$799
Coverage Level *(Maximum of fee paid)*	50%	50%	50%
Amount Delta Dental Pays	$377	$494.50	$399.50
Amount You Pay	$377	$494.50	$399.50

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

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

VISION INSURANCE

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

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

HEALTH SAVINGS ACCOUNT

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

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

COMPANY CONTRIBUTIONS

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

2024 HSA Contributions			
	Butler University Contribution*	**Max Employee Contributions****	**2024 IRS Max Contributions**
Employee Only	$750	$3,400	$4,150
Family	$1,500	$6,800	$8,300
55+ CatchUp	N/A	$1,000	$1,000

**Company contributions are paid in a lump sum by 2/1/2024. Employees hired after 3/31/2024 will receive a pro-rated contribution based on hire date. **Your total maximum contribution into the HSA may not exceed the IRS Contribution Limit for 2024 as shown above.*

MEDICARE

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

MAXIMIZE YOUR TAX SAVINGS WITH AN HSA

use

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

save

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

invest

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

SETTING UP YOUR HSA ACCOUNT

UMB

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

OPENING YOUR HSA ONLINE

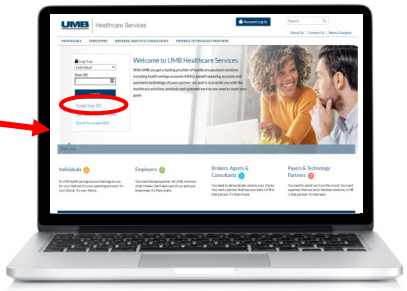
You will need the following information when you begin:

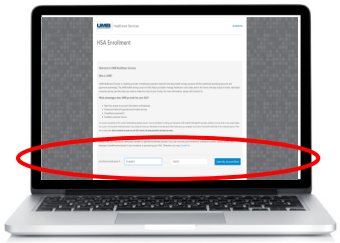
- Enrollment Verification Number: **THA0001 - 143674**

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

STEP 1.

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





STEP 2.

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

The enrollment verification number is specific to Butler University.

STEP 3.

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

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

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

FLEXIBLE SPENDING ACCOUNT (FSA)

WHAT IS A FSA?

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

HOW DOES IT WORK?

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

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

CLAIM FILING AND REIMBURSEMENT

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

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO AN FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule; however, you may roll-over up to $640 year-over-year. Any funds above this amount will be forfeited.
- You cannot take income tax deductions for expenses you pay with your Health FSA and/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.

Annual Health FSA Maximum Contribution Limits	
2024	$3,200

Examples of Eligible Expenses:

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

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts and eye exams, Lasik eye surgery

DEPENDENT CARE FSA

WHAT IS A DEPENDENT CARE FSA?

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

DEPENDENT CARE FSA CONTRIBUTION LIMITS

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

CLAIMS REIMBURSEMENT

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

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

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

EXAMPLES OF ELIGIBLE EXPENSES:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

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

BUDGETING FOR YOUR CARE

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

HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
HSA	**FSA**
HEALTH PLAN ELIGIBILITY Must be enrolled in the **HDHP-HSA** medical plan	**HEALTH PLAN ELIGIBILITY** Must not be enrolled in the **HDHP-HSA** Plan
CONTROL Owned by the employee	**CONTROL** Owned by the employer
FUNDING Butler University & Employee funded *Butler University Funding* *Employee Only: $750* *All Other Tiers: $1,500*	**FUNDING** Employee funded
2024 CONTRIBUTION LIMITS $4,150 single; $8,300 family $1,000 more if age 55+	**2024 CONTRIBUTION LIMITS** Healthcare FSA: $3,200 Dependent Care FSA: $5,000
ROLLOVER AVAILABLE Yes, unlimited	**ROLLOVER AVAILABLE** Up to $640
CAN PARTICIPANTS INVEST FUNDS? Yes	**CAN PARTICIPANTS INVEST FUNDS?** No
TAX ADVANTAGES Yes	**TAX ADVANTAGES** Yes

LIFE AND AD&D INSURANCE

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

BASIC LIFE AND AD&D INSURANCE

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

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

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

VOLUNTARY LIFE INSURANCE

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

- **Employee:** $1,000 increments up to $500,000 (Minimum Election: $10,000); Guarantee Issue: $500,000. Benefit amounts will reduce beginning at age 70.
- **Spouse:** $1,000 increments up to $250,000 or 100% of employee's election, whichever is less (Minimum Election: $10,000); Guarantee Issue: $50,000. Benefit terminates at the end of the plan year a spouse turns age 70.
- **Dependent Child(ren):** <6 months of age - $1,000; 6 months and older - minimum $2,000, increments of $2,000; Guarantee Issue: $10,000. Benefit terminates at the end of the month a dependent turns age 26.

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

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

IMPORTANT BENEFICIARY REMINDERS

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

DISABILITY INSURANCE

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

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

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

NEED A LEAVE OF ABSENCE?

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

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

EMPLOYEE ASSISTANCE PROGRAM

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

SERVICES PROVIDED

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

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

FREE SERVICES

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

CONFIDENTIALITY

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

GETTING STARTED

- Call (855) 365-7454 or
- Visit www.guidanceresources.com
    - **Web ID:** ONEAMERICA6

403B RETIREMENT

Retirement Plan Contributions and Match—TIAA

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

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

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

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

HOW TO ACCESS YOUR RETIREMENT ACCOUNT ONLINE

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

HOW TO CHANGE INVESTMENTS OR TRANSFER FUNDS

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

HOW TO CHANGE BENEFICIARY DESIGNATION

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

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

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

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

Name of Group Health Plan: Butler University Employee Benefit Plan

Notice Regarding Special Enrollment Rights

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

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

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, or placement for adoption. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

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

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

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your benefit materials for specific deductibles and coinsurance that apply.

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

Notice Regarding Michelle's Law

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

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

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

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

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

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

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

Notice Regarding Patient Protection Rights

Your Group Health Plan (identified at the beginning of this section) generally allows the designation of a primary care provider.

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Group Health Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

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

HIPAA Privacy

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that 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, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (indexed) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Plan Administrator (identified at the beginning of this section). The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, including online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility:

ALABAMA Medicaid	**ALASKA Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Fax: 916-440-5676 Email: **hipp@dhcs.ca.gov**
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **https://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/** HIBI Customer Service: 1-855-692-6442	Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html** Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: **https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp** Phone: 678-564-1162, Press 1 GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra** Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: **https://www.in.gov/medicaid/** Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: **https://dhs.iowa.gov/ime/members** Medicaid Phone: 1-800-338-8366 Hawki Website: **http://dhs.iowa.gov/Hawki** Hawki Phone: 1-800-257-8563 HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp** HIPP Phone: 1-888-346-9562	Website: **https://www.kancare.ks.gov/** Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=e n_US** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.mass.gov/masshealth/pa** Phone: 1-800-862-4840 TTY: 711 Email: **masspremassistance@accenture.com**
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084 Email: **HHSHIPPProgram@mt.gov**	Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: **http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx** Phone: 1-800-692-7462 CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)** CHIP Phone: 1-800-986-KIDS (5437)	Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **http://dss.sd.gov** Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services** Phone: 1-800-440-0493	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access** Phone: 1-800-250-8427	Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022	Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN Medicaid and CHIP	WYOMING Medicaid
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

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

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

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

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The prescription drug coverage offered by the Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage through the Group Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit U.S. Social Security on the web at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Wellness Program Privacy Notice

Butler University's wellness program is a voluntary wellness program available to all employees enrolled in the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete an annual physical with your health care provider.

You are not required to complete the annual physical. However, enrolled employees who choose to participate in the wellness program will receive an incentive of $100. Although you are not required to complete the annual physical only enrolled employees who do will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Benefits & Wellness at benefits@butler.edu.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information.

Although the wellness program and Butler University may use aggregate information it collects to design a program based on identified health risks in the workplace, Butler University wellness program will never disclose any of your personal 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 individual(s) who will receive your personally identifiable health information is (are) your health care provider 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 Benefits & Wellness at benefits@butler.edu.

Notice of Rescission of Coverage

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

Summary of Benefits & Coverage (SBC)

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

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

- A summary of the services covered by the plan
- A summary of the services not covered by the plan

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

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

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