LASELL VILLAGE
Senior living at Lasell University

BENEFITS GUIDE

2023 PLAN YEAR

Welcome to Lasell Village's Open Enrollment Period!

Lasell Village recognizes that our employees are the most valuable asset a company can have. In consideration of this, we strive to provide a benefits package that is competitive, mindful of our unique corporate culture, and sensitive to our business needs.

As part of the Lasell Village team, you and your qualified dependents have access to a comprehensive suite of benefits. Today's healthcare challenges are causing Lasell Village, and companies nationwide, to look at how we choose our healthcare coverage, how we are using healthcare services and how we manage our personal health decisions. We believe that through education, innovative solutions and personal commitment we, as a company, can play a role in controlling health care costs for you and Lasell Village. We will do our best to provide you with the necessary information and tools to help you make the right healthcare choices for you and your family.

This guide contains important information about Lasell Village's benefits for the 2023 plan year. It is important to note that the 2023 plan year will be from **January 1st, 2023 through December 31st, 2023.** Please review this guide carefully as you consider changes for you and your family for 2023.

Our open enrollment period will run from **November 7th through November 18th of 2022.**

We encourage employees to use the annual enrollment period as an opportunity to re-evaluate all of your current benefit elections to ensure you are enrolled in appropriate coverage for you and your family.

NOTE: Lasell Village's benefit programs are summarized briefly in this guide. Complete details and limitations are contained in the Summary Plan Description of each plan and appropriate sections of the employee handbook. This guide contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Plan Document or insurance certificate. If you have any questions about a specific service or treatment, please contact the plan's Customer Service Department.

Please note: The availability and amount of all benefits are governed by the legal documents involved. This guide is not a legal document and in no way constitutes a contract of employment.

Benefits Overview

What changes can be made at Open Enrollment?

- Enroll or terminate individual and/or dependent coverage in the medical, dental and vision plans
- Enroll or make changes to coverage in other Lasell Village offered plans
- You must enroll in the plan in order to enroll your dependents

Who do I contact with questions?

- Once enrolled and you have received your benefits cards, you may call the numbers on your cards for specific information and assistance. Phone numbers are also provided towards the end of this enrollment guide.
- Contact Pamela DelliCarpini with any questions or outstanding issues at (617) 663-7058 or via email to pdellicarpini@lasell.edu

Note:

- Benefits are prorated for part-time employees (expected 1,000 hours or more per year to qualify for benefits).

Benefits Overview

Eligibility

You are eligible to enroll in Lasell Village's benefits program if you are a regular employee of Lasell Village working at least 1,000 hours per year.

You may enroll dependents in the medical, dental, vision, and voluntary life plans. Eligible dependents include:

- Spouse
- Dependent children who have not attained age 26
- Dependent children of any age if they became physically or mentally incapable of self-support before age 19 and remain incapacitated and enrolled in the plan

How to Enroll

All employees will be passively enrolled from their 2022 benefit choices into 2023 benefits unless they see HR to make a change by **Friday, November 18th, 2022**!

Making Changes during the Year

Under IRS rules, your health and insurance benefit elections will remain in effect until the next plan year unless you have a qualifying change in status.

Qualifying changes in status include:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child (or placement of a child for adoption)
- Death of a dependent
- Ineligibility of a dependent (for example, your child turns 26)
- A change in you or your partner's employment, if it results in a loss or gain in eligibility for coverage

If you have a qualifying change in status during the year, you must notify HR within 30 days of the status change to request a change to your benefit elections. Otherwise, you will have to wait until the next calendar year. Also, any change in your health benefits or your Flexible Spending Account contributions must be consistent with the change in status. For example, if you get married, you may add your spouse to your current medical plan but you may not change plans.

Carrier Contact Information

Coverage	Carrier Name	Member Services Contact Info	Company Website & Hours of Operation
Medical & Pharmacy	Tufts Health Plan & Optum	(800) 462-0224 1-855-546-3439	www.tuftshealthplan.com
Dental	Delta Dental	(800) 872-0500	www.deltadentalma.com
Vision	VSP	(800) 877-7195	www.vsp.com
Life & Disability	Reliance Standard (RSLI)	(800) 351-7500	www.customercare.rsli.com
Voluntary Life	Reliance Standard (RSLI)	(800) 351-7500	www.customercare.rsli.com
Health & Dependent Care Spending Accounts	Benefit Strategies	(888) 401-3539	www.benstrat.com
Health Savings Account	Benefit Strategies	(888) 401-3539	www.benstrat.com
Retirement Plan	TIAA-CREF	(800) 842-2252	www.tiaa-cref.com
Employee Assistance Plan (EAP)	New Directions	(800) 624-5544	eap.ndbh.com
Identity Theft Protection	Reliance Standard (Partnered with InfoArmor)	(855) 246-7347	www.reliancestandard.com/walletarmor
Travel Assistance	Reliance Standard (Partnered with On Call International)	US: (800) 456-3893 International: (603)-328-1966	www.reliancestandard.com

Employee Contributions

The employee contributions effective January 1, 2023 are noted below for each line of coverage.

Medical Contributions (26 Checks)

	EPO - Value		EPO – HDHP	
	Employer Cost	Your Cost	Employer Cost	Your Cost
Individual	$368.64	$88.16	$330.54	$56.06
Family	$865.17	$374.33	$739.54	$309.45

Cost Per Pay Period for **Part-Time Employees** working 20 or more hours per week/.5 Full-time Equivalent. The Village's contribution will be pro-rated 1/1/23 – 12/31/23

Part-Time Medical Contributions (26 Checks)

	EPO - Value		EPO – HDHP	
	Employer Cost	Your Cost	Employer Cost	Your Cost
Individual	$324.56	$132.24	$302.51	$84.09
Family	$678.01	$561.50	$584.82	$464.18

Dental Contributions (26 Checks)

	Dental High	Dental Low
Individual	$25.61	$19.27
Family	$68.57	$51.59

Vision Contributions (26 Checks)

	VSP Signature Plan
Individual	$4.80
Family	$10.31

Medical Coverage

Lasell Village is pleased to offer two medical plans through Tufts Health Plan. The plan benefits for each plan are illustrated below:

	EPO (HMO) Value	Health Savings Account (HMO)
In-Network Calendar Year Deductible	None	Employee - $1,500 Family - $3,000
Calendar Year Out-of-Pocket Maximum	Employee - $2,500 Family - $5,000	Employee - $2,500 Family - $5,000
Urgent Care	$25 copay	$0 after deductible
Office Visits	$25 copay	$0 after deductible
Specialist Visits	$25 copay	$0 after deductible
Preventative Health Care Services **	Covered in full	Covered in full
Chiropractic / Acupuncture Benefit	$25 copay – 30 visits	$0 after deductible – 30 visits
Hearing Aid Benefit	$2,000 per ear every 36 months (no age limit)	$2,000 per ear every 36 months (no age limit)
High Tech Imaging (CT, MRI, PET Scans)	$75 copay	$0 after deductible
Lab Tests & X-Ray	Covered in full	$0 after deductible
Emergency Room Visit *(Waived if Admitted to Hospital)*	$150 copay	$0 after deductible
Outpatient Surgery Facility	$250 copay	$0 after deductible
Inpatient Hospitalization	$500 copay	$0 after deductible
Prescription Drug Coverage (*Retail 30 day supply*)	$5 / $20 / $30 / $50	After Deductible $5 / $20 / $30 / $50
Prescription Drug Coverage (*Mail Order 90 day supply*)	$10 / $40 / $60 / $150	After Deductible $10 / $40 / $60 / $150
Out of Network Calendar Year Deductible	N/A	N/A
Calendar Year Out-of-Pocket Maximum	N/A	N/A
Coinsurance	N/A	N/A

** Preventative Health Care Services include adult routine physical exams (1 per calendar year), well child visits, mammogram & Pap test, colonoscopy, prostate cancer screening, adult immunizations.

Dental Coverage

Lasell Village offers two dental plans through Delta Dental. The plan benefits for each plan are illustrated below:

Note: This plan is voluntary, meaning that the employee pays for the full cost of coverage

	High Plan	
	In-Network	**Out-of-Network**
Type I: Preventative Services	100%	100%
Type II: Basic Services	90%	80%
Type III Services	50%	50%
Deductible (Waived for Preventative Services)	$50 Individuals $150 Family	
Annual Maximum per Individual	**$2,000**	

	Low Plan	
	In-Network	**Out-of-Network**
Type I: Preventative Services	100%	100%
Type II: Basic Services	80%	60%
Type III Services	50%	30%
Deductible (Waived for Preventative Services)	$50 Individuals $150 Family	
Annual Maximum per Individual	**$1,500**	

In-Network: Plan utilizes participating dentists
Out-of-Network: Allows freedom of choice, but there may be additional out-of-pocket costs

Vision Benefits

A summary of the Vision Plan benefits is illustrated below.

Note: *This plan is voluntary, meaning that the employee pays for the full cost of coverage*

	VSP Signature Plan	
	In-Network	**Out-of-Network**
Eye Exam / 12 Months	$20 copay	Up to $50
Lenses / 12 Months	$20 copay	After $20 copay, Single – Up to $50 Bifocal – Up to $75 Trifocal – Up to $100 Lenticular – Up to $125
Frames / 12 Months	$130 allowance after $20 copay, 20% off amounts over allowance	After $20 copay, Up to $70
Contact Lenses / 12 Months **(in lieu of lenses & frames)**	$20 copay – medically necessary $130 allowance - elective	After $20 copay, Medically necessary – Up to $210 Elective – Up to $105

Health Care & Dependent Care FSA

A flexible spending account allows employees to set aside pretax income to pay for health, dental, vision and dependent care expenses that are expected to occur during the year. The maximum amount you can fund your FSA account is $3,050 for health, dental, and vision and $5,000 for dependent care (or $2,500 if married and filing separately).

Enrollment in the FSA is not dependent on whether you are enrolled in Lasell Village's medical or dental plan.

Contributions to your FSA come out of your paycheck before taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period.

Lasell Village includes a rollover provision and allows employees to carryover up to $610 from the current plan year to the next plan year for unreimbursed expenses.

Any funds remaining at the end of the plan year above $610 will not be rolled over, as the FSA is a "use it or lose it" benefit.

You must reenroll each year with a new election to be a part of the plan in 2023.

Examples of IRS-approved medical care expenses include:

- Co-pays, Deductibles and Coinsurance
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Hearing services, including hearing aids and batteries
- Dental services and orthodontia
- Chiropractic services
- Prescription contraceptives

Dependent Care FSA

With the Dependent Care FSA, Lasell Village employees use pre-tax dollars towards qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

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

Health Care & Dependent Care FSA

Limited Purpose FSA *(For those enrolled in the HSA Plan only)*

This account will reimburse you with pre-tax dollars for dental and vision expenses only until you meet your Qualified High Deductible HSA plan deductible. Qualified expenses are those that are not reimbursed under your current plan(s) such as dental coinsurance, and deductibles for elective surgery, like laser eye surgery.

The maximum you may elect on the Limited Purpose FSA is $3,050/year.

Health Savings Account (HSA)

The HSA is administered through Benefit Strategies. You will have access to a secure website to manage your Health Savings Account funds. If you elect the Qualified High Deductible HSA plan, please note that Benefit Strategies may need to verify information to open up the HSA account and will mail information directly to your home.

HSA Account Eligibility

Health Savings Account plans have special tax advantages and the IRS defines specific rules for participation. To be eligible, you:

- Must be enrolled in an IRS qualified high deductible medical plan
- Cannot have any other health coverage
- Not Covered by Spouse's medical or prescription plan
- Not Covered through Medicare Part A or Part B
- Not covered through a Medical Spending Account (FSA) plan (either employer's or spouse's)
- Cannot be claimed as a dependent on another person's tax return
- Not received Veterans Administration (VA) benefits within the past three months
- Not received health benefits under TriCare

HSA Funding and Eligible Expenses

Lasell Village will continue to make HSA contribution at the beginning of the plan year as follows:

$750: Individual plans

$1,500: Family plans

You may also contribute money, pre-tax, into your account. All HSA funds can be used to pay for eligible medical expenses, as well as dental and vision expenses.

Funds can be invested much like 403(b) funds are invested. Also, your HSA account is owned by you, so you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after your retirement, you may withdraw the money as cash. Money in your account rolls over year to year and accumulates. Unlike the FSA there is no use it or lose it feature. Employees are able to use their HSA fund dollars for any Section 213 expenses including medical, pharmacy, dental and vision expenses. A complete list of eligible expenses is available to you through Benefit Strategies.

Health Savings Account (HSA)

HSA Contribution Limits

The IRS imposes a maximum contribution limit to the HSA on a calendar year basis. The following chart shows the 2022 maximum limits, the Lasell Village contribution and the amount employees may contribute during 2023.

Under Age 55

2023	Lasell Village Contribution	Employee Contribution	Total Allowed Contribution
Individual	$750	$3,100	$3,850
Family	$1,500	$6,250	$7,750

Age 55 + Catch up Contribution*

If you are 55 or older, you can make "catch-up" contributions, meaning you can deposit an additional $1,000 per year. If your spouse is also 55 or older, he or she may establish a separate HSA and make a "catch-up" contribution to that account.

2023	Lasell Village Contribution	Employee Contribution	Total Allowed Contribution
Individual	$750	$4,100	$4,850
Family	$1,500	$7,250	$8,750

**Catch-up contributions can be made any time during the year in which the HSA participant turns 55.*

NOTE: Funds can be used only as they are available in the account. You can pay the remaining balance with another source (check, credit card, etc.) and reimburse yourself with HSA funds as they become available with additional contribution deposits.

Please note: Only a Limited Purpose Flexible Spending Account (FSA) can be used while participating in an HSA plan.

Life & Disability Insurance

Reliance Standard will continue to be our Life & Disability carrier for the 2023 plan year

Basic Life/AD&D Insurance

Lasell Village provides each eligible employee, a Life and Accidental Death & Dismemberment (AD&D) Insurance benefit equal to 1.5 X times your annual salary to a maximum of $200,000 at no cost to you. Accidental Death and Dismemberment (AD&D) may pay a benefit equal to your Life Insurance if your death is the result of an accident. If you suffer an injury, such as the loss of a limb or an eye, you may receive a partial AD&D benefit.

Benefit Age Reduction: 35% at age 70

Employee Supplemental Life and AD&D Insurance

Lasell Village employees also have the opportunity to purchase Supplemental Life Insurance for themselves up to 5X your annual base salary in $1,000 increments. You can qualify for coverage up to $200,000 without any medical questions if you apply when initially eligible.

If you elect Supplemental Insurance for yourself, you may also purchase supplemental life insurance for your spouse and/or dependent child(ren). Spousal life is available up to 100% of employee coverage to $500,000 in increments of $1,000. Your spouse can qualify for coverage up to $30,000 without any medical questions. Dependent life is available for children from 6 months to 26 years old (if still a student) up to $10,000 in $1,000 increments.

Children under 6 months are eligible for life insurance up to $1,000. Accidental Death and Dismemberment (AD&D) amounts match the life coverage amount. You can apply for coverage during open enrollment however will be required to provide evidence of insurability.

Short Term Disability:

Lasell Village provides employees with Short Term disability insurance through Reliance Standard. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. Lasell Village pays for the cost of this insurance.

Short Term Disability Overview	
Maximum Benefit	60% of your salary
Maximum Benefit Period	6 months
Elimination Period	14 days maternity;45 days for illness

Long Term Disability:

Long Term Disability (LTD) insurance helps protect your family's financial security. It is intended to replace a percentage of your lost income if you are unable to work due to injury or illness. The LTD policy will be insured through Reliance Standard. Lasell Village pays for the cost of this insurance.

Long Term Disability Overview	
Benefits Begin	After you have been disabled 180 days
Maximum Monthly Benefit	60% of your salary to $10,000 per month
Benefit Period	To age 65

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

The Employee Assistance Program is provided through New Directions at no cost to you and your family members. The program offers confidential Employee Assistance Services, as well as one-on-one telephonic and online coaching, budget, financial, and legal consultations. See the EAP Services Flyer for additional information and visit their website at eap.ndbh.com, using company code Lasell Village. Or if you prefer, talk with a specialist Toll-free, 24 hours a day / 7 days a week at 800-624-5544.

Employees and their household members may use EAPs to help manage issues in their personal lives. EAP counselors typically provide assessment, support, and referrals to additional resources such as counselors for a limited number of program-paid counseling sessions. The issues for which EAPs provide support vary, but examples include:

- Substance abuse
- Occupational stress
- Emotional distress
- Major life events, including births, accidents and deaths
- Health care concerns
- Financial or non-work-related legal concerns
- Family/personal relationship issues
- Work relationship issues
- Concerns about ageing parents

Who is Eligible and When:

All employees and family members

Benefits You Receive:

When you have questions, concerns or emotional issues surrounding your personal or work life, e4Health is available to help. Through New Directions work-life balance employee assistance program (EAP), you have unlimited access to consultants by telephone, resources and tools online, and up to three face-to-face visits with counselors for help with a short-term problem.

Additional Benefits

Retirement Plan

Eligible employees are able to participate in Lasell Village's tax-deferred 403(b) Retirement Plan through TIAA-CREF. Employees of the Village become eligible to participate on a voluntary basis as of their date of hire. Participating, eligible employees who complete one year of employment and contribute a minimum of 2% may receive a match to their contributions of up to 7.5% from the Village. The 403(b) maximum for 2023 is $22,500.

Identity Theft Protection (Through Reliance Standard)

To protect you and your family from this devastating loss, RSLI and Lasell Village have provided you with a full service ID Recovery Program that will perform the recovery process for you should you or a member of your family fall victim to identity theft. You also have access to real-time card monitoring through InfoArmor. If you suspect your personal information has been compromised, call toll free: 1.855.246.7347

Travel Assistance (Through Reliance Standard)

Reliance Standard has partnered with On Call International to provide around-the-clock access to On Call International's 24-hour, toll-free travel assistance services. Whether you need help with an illness or injury, lost passport, missing luggage or even a prescription refill, you can rest assured you (and your covered dependents) have access to a personal travel emergency companion anytime you're more than 100 miles away from home. To get in touch with On Call International while in the U.S. please call 800-456-3893. Worldwide, please call 603-328-1966.

Additional Benefits

Tuition Waiver for Employees and Dependents

Employees may be eligible to receive a tuition waiver for Lasell University courses beginning the semester following their date of hire. Qualifying dependents of employees may be eligible after the employee has completed one year of service.

Tuition Reimbursement

Employees may receive Tuition Reimbursement for pre-approved work-related classes at an outside institution for up to $1,000 per year.

Where to learn more:

	Insurance Company Contact Info
Tufts Health Plan Member Services	(800) 462-0224
Look up your Medical Information and Manage your Coverage	Register at: www.tuftshealthplan.com
Optum Pharmacy Benefit	(855) 546-3439
Delta Dental Member Services	(800) 872-0500 / www.deltadentalma.com
VSP Member Services	(800) 877-7195 / www.vsp.com
Reliance Standard Member Services	(800) 351-7500 / www.customercare.rsli.com
Benefit Strategies	(888) 401-3539 / www.benstrat.com
TIAA-CREF	(800) 842-2252 / www.tiaa-cref.com
New Directions	(800) 624-5544 / eap.ndbh.com

Questions on your benefit plans?
Contact Pamela DelliCarpini at Human Resources at
(617) 663-7058 or email at pdellicarpini@lasell.edu

Required Annual Federal Compliance Notices

Important Information

Please Read

Model Disclosure Notices

1. Special Enrollment Rights

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

See the Plan Administrator for details about special enrollment.

2. Grandfathered Status

The Plan believes that none of the group health plans available under the Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

3. Special Rule for Maternity and Infant Coverage

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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

4. Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers, and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

5. Notice Regarding Lifetime and Annual Dollar Limits

In accordance with applicable law, none of the lifetime dollar limits and annual dollar limits set forth in the Plan shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan

Administrator of the guidance available as of the date on which the determination is made.

6. Patient Protection Disclosure

You have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

7. Affordable Care Act Consumer Protections

(a.) Coverage for Children Up to Age of 26

The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent, or a student.

(b.) Prohibition of Lifetime Dollar Value of Benefits

The Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on the dollar value of benefits.

(c.) Your Health Insurance Cannot be Rescinded

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage under the Plan for misrepresentation.

(d.) Prohibition of Pre Existing Conditions

Effective January 1, 2014 The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from denying any health insurance claim for any person because of pre-existing condition.

(e.) Prohibition of Restrictions on Annual Limits on Essential Benefits

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January 1, 2014 from placing annual limits on the value of essential health benefits.

(f.) Notice of Marketplace/Exchange

If this health insurance is unaffordable (your cost of the premium exceeds 9.5% of your income) as defined under the Affordable Care Act , you may have the right to subsidized health insurance purchased through an exchange/marketplace created pursuant to the Affordable Care Act.

8. Michelle's Law

Michelle's Law provides continued health and dental insurance benefits under the Plan for dependent children who are covered under the Plan as a student but lose their student status in a post-secondary school or college because they take a medically necessary leave of absence from school. If your child is no longer a student because he or she is out of school because of a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

9. The Genetic Information Nondiscrimination Act (GINA)

GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

10. Wellness

If your Plan includes a Wellness program that provides rewards or surcharges based on your ability to complete an activity or satisfy an initial health standard, you have the right to request a reasonable alternative should it be determined that it is not medically advisable for you to either complete the activity or satisfy the initial health standard.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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, 2018. You should contact your State for further information on eligibility:

Alabama – Medicaid
Alaska – Medicaid
Arkansas – Medicaid
Colorado – Medicaid & CHIP
Florida – Medicaid
Georgia – Medicaid
Indiana – Medicaid
Iowa – Medicaid
Kansas – Medicaid
Kentucky – Medicaid
Louisiana – Medicaid
Maine – Medicaid
Massachusetts – Medicaid & CHIP
Minnesota – Medicaid
Missouri – Medicaid
Montana – Medicaid
Nebraska – Medicaid
Nevada – Medicaid & CHIP
New Hampshire – Medicaid
New Jersey – Medicaid & CHIP
New York – Medicaid
North Carolina – Medicaid
North Dakota – Medicaid
Oklahoma – Medicaid & CHIP
Oregon – Medicaid
Pennsylvania – Medicaid
Rhode Island – Medicaid
South Carolina – Medicaid
South Dakota – Medicaid
Texas – Medicaid
Utah – Medicaid & CHIP
Vermont – Medicaid
Virginia – Medicaid & CHIP
Washington – Medicaid
West Virginia – Medicaid
Wisconsin – Medicaid & CHIP
Wyoming – Medicaid

To see if any more States have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Security Administration

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee Benefits
Centers for Medicare & Medicaid Services www.dol.gov/ebsa
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

****Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Pamela DelliCarpini.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

HR Contact Name: Pamela DelliCarpini
Email Address: PDelliCarpini@lasell.edu
Phone Number: 617-663-7058

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20221, calling 1-877-696- 6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/ complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective service

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

Important Notice from Lasell Village
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lasell Village 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 EPO 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. Lasell Village has determined that the prescription drug coverage offered by the Tufts Medical 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 to 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 Lasell Village coverage will not be affected unless you drop the Tufts sponsored medical plan.

Generally speaking, if you enroll in Medicare Part D and are also covered by a Lasell Village medical plan your prescription drug benefits under this Plan are not affected by your Medicare enrollment as this Plan will be primary and Medicare will be secondary (there may be some exceptions, such as if you have end-stage renal disease or are disabled). Your plan summary describes your prescription drug coverage under the Plan.

You may choose, however, to drop your coverage under this Plan and be covered only by Medicare, including Part D, in which case Medicare will determine your benefits.

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 with Lasell Village 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 nineteen 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 the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lasell Village changes. You also may request a copy of this notice at any time.

Human Resources Lasell Village
(617) 663-7058

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 Social Security on the web at www.socialsecurity.gov or call them at 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).

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.