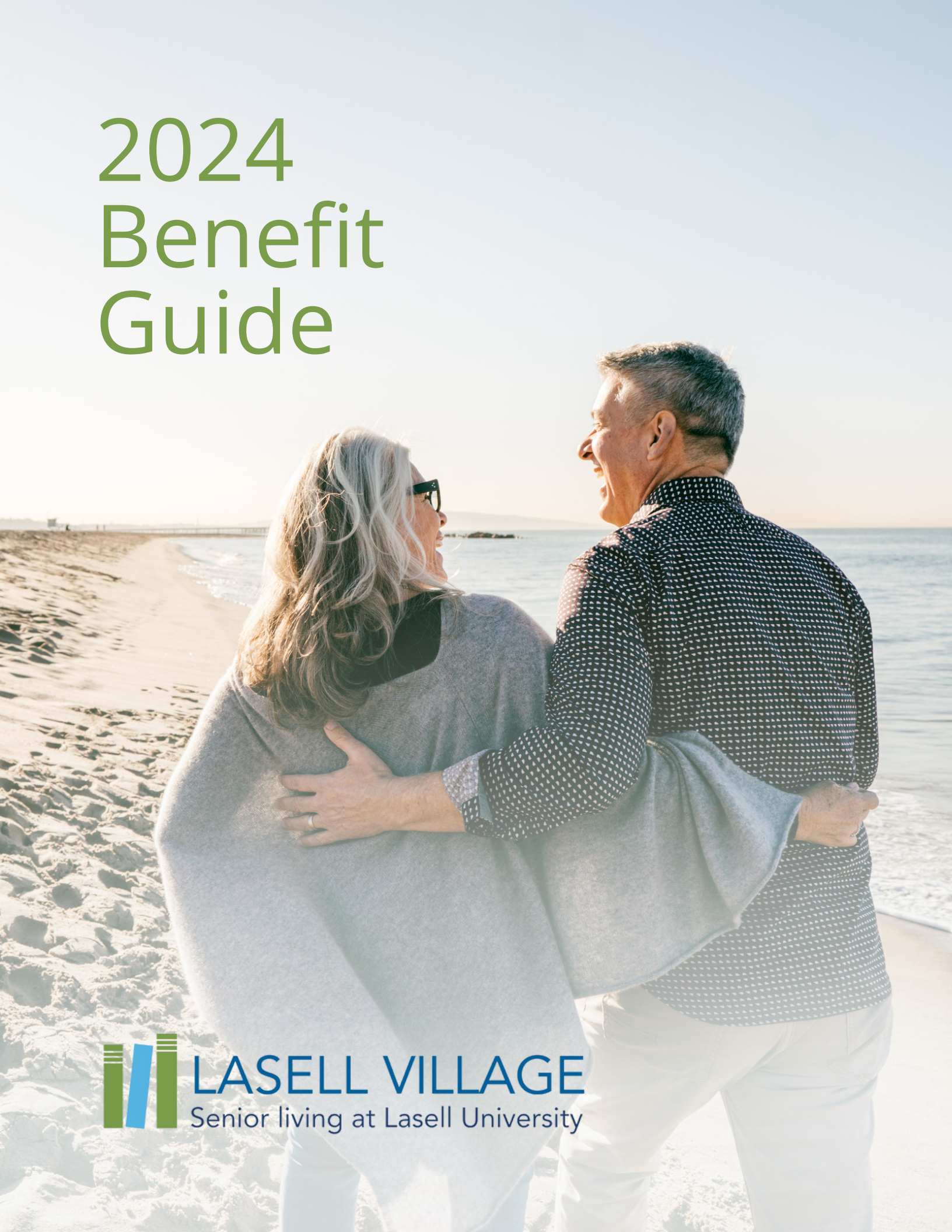
2024 Benefit Guide



LASELL VILLAGE
Senior living at Lasell University

What's Inside?

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 youand your family.

This guide contains important information about Lasell Village's benefits for the 2024 plan year. It is important to note that the 2024 plan year will be from January 1st, 2024 through December 31st, 2024. Please review this guide carefully as you consider changes for you and your family for 2024. Our open enrollment period will run from **November 6, 2023 through November 17, 2023**. 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.

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*).

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***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*

Eligibility & Enrollment

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:

- Your legal 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 2023 benefit choices into 2024 benefits unless they see HR to make a change by November 17, 2023**!**

Changing Benefits After Enrollment

During your enrollment period at your time of hire or during the annual enrollment, you have the opportunity to add or update your benefit elections. Changes outside of this Open Enrollment period may only be made if you experience a qualifying event, as determined by the IRS.

Qualifying life events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a qualified dependent
- Change in residence due to employment
- Change in spouse's benefits or employment

IMPORTANT NOTE

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.

Medical Glossary

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit

A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance

The percentage of a covered expense you must pay after you meet your deductible, but before you reach the annual out-of-pocket maximum. The remaining percentage is paid by the health plan.

Copayment

The per-service fixed fee you pay for certain covered medical expenses.

Deductible

The amount you must pay each year for medical expenses before the medical plan begins to pay benefits.

Preventive Care

Services available to you, such as screenings, vaccinations, and counseling, that can help you avoid illness.

Guarantee Issue Amount

The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form, and be approved for your coverage amount.

In Network

Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out of Network

Providers who don't contract with your insurance carrier. Out of network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount *(see Balance Billing)*.

Out of Pocket Maximum

The limit the medical plan puts on the amount of money you have to pay each year out of your pocket for eligible medical expenses. Once you reach the limit, the plan will pay 100% of your eligible expenses for the rest of the year.

Prescription Drug Formulary

A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Medical Coverage

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

Harvard Pilgrim Health Care	EPO (HMO) Value	Health Savings Account (HMO)
	In Network	In Network
Deductible (*Individual / Family*)	N/A	$1,600 / $3,200
Out of Pocket Max (*Individual / Family*)	$2,500 / $5,000	$2,500 / $5,000
Preventive Care Visit*	Covered in full	Covered in full
Office Visits	$25 copay	$0 after deductible
Specialist Visit	$25 copay	$0 after deductible
Chiropractic and Acupuncture Benefits	$25 copay - unlimited visits	$0 after deductible - unlimited visits
Hearing Aid Benefit	$2,000 per ear every 36 months (no age limit)	$2,000 per ear every 36 months (no age limit)
Urgent Care Visit	$25 copay	$0 after deductible
Emergency Room Visit	$150 copay	$0 after deductible
Inpatient Hospital	$500 copay	$0 after deductible
Outpatient Surgery	$250 copay	$0 after deductible
Diagnostics (*Labs / X-Ray*)	Covered in full	$0 after deductible
High Tech Imaging (*MRI, CT, PET Scans*)	$75 copay	$0 after deductible
Prescription Drugs		*after deductible:*
Retail Pharmacy (*30 Day Supply*)	$5 / $20 / $30 / $50	$5 / $20 / $30 / $50
Mail Order (*90 Day Supply*)	$10 / $40 / $60 / $150	$10 / $40 / $60 / $150

Scan the QR code with your smartphone to learn more about HMO medical plans.

**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.*

Medical Coverage

The employee contributions effective January 1, 2024 are noted below for each line of coverage.

Your Medical Plan Costs

Full Time	Harvard Pilgrim Health Care HMO		Harvard Pilgrim HDHP HSA (HMO)	
	Employer Cost	Your Cost	Employer Cost	Your Cost
Individual	$404.19	$91.95	$361.41	$58.47
Family	$955.79	$390.43	$816.55	$322.76

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 1/1/24 – 12/31/24

Part Time	Harvard Pilgrim Health Care HMO		Harvard Pilgrim HDHP HSA (HMO)	
	Employer Cost	Your Cost	Employer Cost	Your Cost
Individual	$358.21	$137.93	$332.18	$87.70
Family	$760.58	$585.64	$655.17	$484.14

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.*

Delta Dental	High Plan		Low Plan	
	In Network	Out of Network	In Network	Out of Network
Type 1: Preventive *oral exams, cleanings, x-rays*	covered 100%, no deductible	covered 100%, no deductible	covered 100%, no deductible	covered 100%, no deductible
Type 2: Basic Restorative *fillings, oral surgery*	covered 90% after deductible	covered 80% after deductible	covered 80% after deductible	covered 60% after deductible
Type 3: Major Restorative *implants, crowns*	covered 50% after deductible	covered 50% after deductible	covered 50% after deductible	covered 30% after deductible
Calendar Year Deductible	Individual: $50 Family: $150		Individual: $50 Family: $150	
Calendar Year Maximum	$2,000 per member		$1,500 per member	

Your Dental Plan Costs

Contributions (26 Checks)	High Plan	Low Plan
Individual	$25.61	$19.27
Family	$68.57	$51.59

DELTA DENTAL®

Vision Coverage

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 *(member cost)*	Out of Network
Examinations	$20 copay	Up to $55
Standard Lens Options Single Vision Bifocal Trifocal Lenticular	$20 copay	Up to $50 Up to $75 Up to $100 Up to $125
Frames	$130 allowance after $20 copay 20% off amounts over allowance	Up to $70
Contact Lenses (*instead of glasses)* Medically Necessary Elective	$20 copay $130 allowance	Up to $210 Elective Up to $105
Frequency *Examination* *Lenses or Contact Lenses* *Frames*	Once every 12 months Once every 12 months Once every 12 months	N/A

Your Vision Plan Costs

Contributions (26 Checks)	VSP
Individual	$4.80
Family	$10.31

Flexible Spending Accounts

Healthcare FSA

An FSA allows employees to set aside pre-tax 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 $3,200 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 $640 from the current plan year to the next plan year for unreimbursed expenses. Any funds remaining at the end of the plan year above $640 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 2024.

Examples of IRS-approved medical care expenses include:

- Copays, 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 in or out of your house
- Nursery schools & preschools *(excluding kindergarten)*

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 $3,200/year.

Health Savings Account

The HSA is administered through Voya. 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 Voya 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:

- **Individual plans:** $750
- **Family plans:** $1,500

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 Voya.

VOYA FINANCIAL

Health Savings Account

HSA Contribution Limits

The IRS imposes a maximum contribution limit to the HSA on a calendar year basis. The following chart shows the 2024 maximum limits, the Lasell Village contribution and the amount employees may contribute during 2024.

Under Age 55

2024 Contribution Limits	Lasell Village Contribution	Employee Contribution	Total Allowed Contribution
Individual	$750	$3,400	$4,150
Family	$1,500	$6,800	$8,300

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.

2024 Contribution Limits	Lasell Village Contribution	Employee Contribution	Total Allowed Contribution
Individual	$750	$4,400	$5,150
Family	$,1500	$7,800	$9,300

**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.

IMPORTANT NOTE

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

VOYA FINANCIAL

Life & Disability Coverage

Basic Life/Accidental Death & Dismemberment (AD&D)

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.

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 $10,000 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 $5,000. 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 $2,000 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 (STD)

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.

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

Long Term Disability (LTD)

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.

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

The Employee Assistance Program (EAP) is provided through ACI 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 **rsli.acieap.com**, **company code: RSLI859**. Or if you prefer you can talk with a specialist Toll-free, 24 hours a day / 7 days a week at 855-775-4357.

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 are eligible for this benefit the 1st of the month following your date of hire.

Benefits You Receive:

When you have questions, concerns or emotional issues surrounding your personal or work life, ACI is available to help. Through ACI's 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 2024 is $23,000.

TIAA

Identity Theft Protection

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: **855-246-7347**.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Travel Assistance

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**.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

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

Coverage	Carrier	Phone	Website
Medical	Harvard Pilgrim Health Care	866-623-0184	harvardpilgrim.org
Dental	Delta Dental	(800) 872-0500	deltadentalma.com
Vision	Vision Service Plan	(800) 877-7195	vsp.com
Life & Disability	Reliance Standard (RSLI)	(800) 351-7500	customercare.rsli.com
Voluntary Life	Reliance Standard (RSLI)	(800) 351-7500	customercare.rsli.com
Health & Dependent Care Spending Accounts	Voya	(833) 232-4673	www.voya.com/page/bsl
Health Savings Account	Voya	(833) 232-4673	www.voya.com/page/bsl
Retirement Plan	TIAA-CREF	(800) 842-2252	tiaa-cref.com
Employee Assistance Plan (EAP)	ACI	(855) 775-4357	rsli.acieap.com
Identity Theft Protection	Reliance Standard (Partnered with InfoArmor)	(855) 246-7347	reliancestandard.com/wall etarmor
Travel Assistance	Reliance Standard (Partnered with On Call International)	US: (800) 456-3893 International: (603) 328-1966	reliancestandard.com
Human Resources	Pamela DelliCarpini	(617) 663-7058	pdellicarpini@lasell.edu

Required Annual Notices

HIPAA

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.

Notice Regarding Lifetime & 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.

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.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, a covered employee's becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child's loss of dependent status (and therefore coverage) under the plan. COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

The Genetic Information Non-Discrimination 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.

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.

Mental Health Parity & Addiction Equity

The Medical Plan provides the same coverage for any mental health service as are provided for medical coverage. This means that stated medical deductibles, copays, coinsurance and out-of-pocket limits will also apply to mental health services.

Special Rule for Maternity & 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).

Required Annual Notices

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").

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 a 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 9.12% 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.

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.

Premium Assistance Under Medicaid & 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 **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 **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 **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
myalhipp.com or 1-855-692-5447
ALASKA - MEDICAID
The AK Health Insurance Premium Payment Program: myakhipp.com or 1-866-251-4861 or email CustomerService@MyAKHIPP.com **Medicaid Eligibility:** health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - MEDICAID
myarhipp.com or 1-855-MyARHIPP (855-692-7447)

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CALIFORNIA - MEDICAID

Health Insurance Premium Payment (HIPP) Program: dhcs.ca.gov/hipp or 916-445-8322 or hipp@dhcs.ca.gov

COLORADO - HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado: healthfirstcolorado.com
Health First Colorado Member Contact Center
Phone: 1-800-221-3943 / State Relay: 711
CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay: 711
Health Insurance Buy-In Program (HIBI):
colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA - MEDICAID

Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268

GEORGIA - MEDICAID

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

INDIANA - MEDICAID

Healthy Indiana Plan for low-income adults 19-64:
in.gov/fssa/hip or 1-877-438-4479
All other Medicaid: in.gov/medicaid or 1-800-457-4584

IOWA - MEDICAID AND CHIP (HAWKI)

Medicaid Website: dhs.iowa.gov/ime/members or 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki or 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp or 1-888-346-9562

KANSAS - MEDICAID

kancare.ks.gov or 1-800-792-4884

KENTUCKY - MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328 or email KIHIPP.PROGRAM@ky.gov
KCHIP: kidshealth.ky.gov/Pages/index.aspx or 1-877-524-4718
Kentucky Medicaid: https://chfs.ky.gov

LOUISIANA - MEDICAID

medicaid.la.gov or ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - MEDICAL

Enrollment: maine.gov/dhhs/ofi/applications-forms or 1-800-442-6003 or TTY: Maine relay 711
Private Health Insurance Premium:
maine.gov/dhhs/ofi/applications-forms or 800-977-6740 or TTY: Maine relay 711

MASSACHUSETTS - MEDICAID AND CHIP

mass.gov/masshealth/pa or 1-800-862-4840 or TTY: 617-886-8102

MINNESOTA - MEDICAID

mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp or 1-800-657-3739

MISSOURI - MEDICAID

dss.mo.gov/mhd/participants/pages/hipp.htm or 573-751-2005

MONTANA - MEDICAID

dphhs.mt.gov/MontanaHealthcarePrograms/HIPP or 1-800-694-3084 or HHSHIPPProgram@mt.gov

NEBRASKA - MEDICAID

ACCESSNebraska.ne.gov or 1-855-632-7633
Lincoln: 402-473-7000 **Omaha:** 402-595-1178

NEVADA - MEDICAID

dhcfp.nv.gov or 1-800-992-0900

NEW HAMPSHIRE - MEDICAID

dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program or 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY - MEDICAID AND CHIP

Medicaid: state.nj.us/humanservices/dmahs/clients/medicaid or 609-631-2392
CHIP: njfamilycare.org/index.html or 1-800-701-0710

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NEW YORK - MEDICAID

health.ny.gov/health_care/medicaid or 1-800-541-2831

NORTH CAROLINA - MEDICAID

medicaid.ncdhhs.gov or 919-855-4100

NORTH DAKOTA - MEDICAID

nd.gov/dhs/services/medicalserv/medicaid or 1-844-854-4825

OKLAHOMA - MEDICAID AND CHIP

insureoklahoma.org or 1-888-365-3742

OREGON - MEDICAID

healthcare.oregon.gov/Pages/index.aspx or oregonhealthcare.gov/index-es.html or 1-800-699-9075

PENNSYLVANIA - MEDICAID

dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
1-800-692-7462

RHODE ISLAND - MEDICAID AND CHIP

eohhs.ri.gov or 1-855-697-4347 or 401-462-0311

SOUTH CAROLINA - MEDICAID

scdhhs.gov or 1-888-549-0820

SOUTH DAKOTA - MEDICAID

dss.sd.gov or 1-888-828-0059

TEXAS - MEDICAID

gethipptexas.com or 1-800-440-0493

UTAH - MEDICAID AND CHIP

Medicaid: medicaid.utah.gov
CHIP: health.utah.gov/chip or 1-877-543-7669

VERMONT - MEDICAID

greenmountaincare.org or 1-800-250-8427

VIRGINIA - MEDICAID AND CHIP

coverva.org/en/famis-select or coverva.org/en/hipp
Medicaid: 1-800-432-5924 **CHIP:** 1-800-432-5924

WASHINGTON - MEDICAID

hca.wa.gov or 1-800-562-3022

WEST VIRGINIA - MEDICAID AND CHIP

dhhr.wv.gov/bms or mywvhipp.com
Medicaid: 304-558-1700
CHIP: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - MEDICAID AND CHIP

dhs.wisconsin.gov/badgercareplus/p-10095.htm or 1-800-362-3002

WYOMING - MEDICAID

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility or 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
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibility

This notice describes how health information about you, including your payment for health insurance, may be used and disclosed by our health plan under the Health Insurance Portability and Accountability Act (HIPAA) 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 you 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. 20201, calling 1-877-696-6775, or visiting 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.

Notice of Privacy Practices

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 we never share your information unless you give us written permission:	• Marketing Purposes • Sale of your information
How do we typically use or share your health information?	We generally do not use your health information for purposes other than administering the company's health plan. HIPAA does allow us, however, if we were to choose to do so, to use or share your health information in our possession the following ways.
Health manage the health care treatment you receive.	We can use your health information and share it with professionals who are treating you. **Example:** We use health information about you to develop better services for you.
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. That 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.
Health 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.

Notice of Privacy Practices

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: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

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: **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.

- The Effective Date of this Notice is January 1, 2024
- This Notice will serve as Notice for the following benefit enrolled employees:
  - Lasell Village

LASELL VILLAGE
Senior living at Lasell University

MarshMcLennan Agency