

2024 Benefits Guide

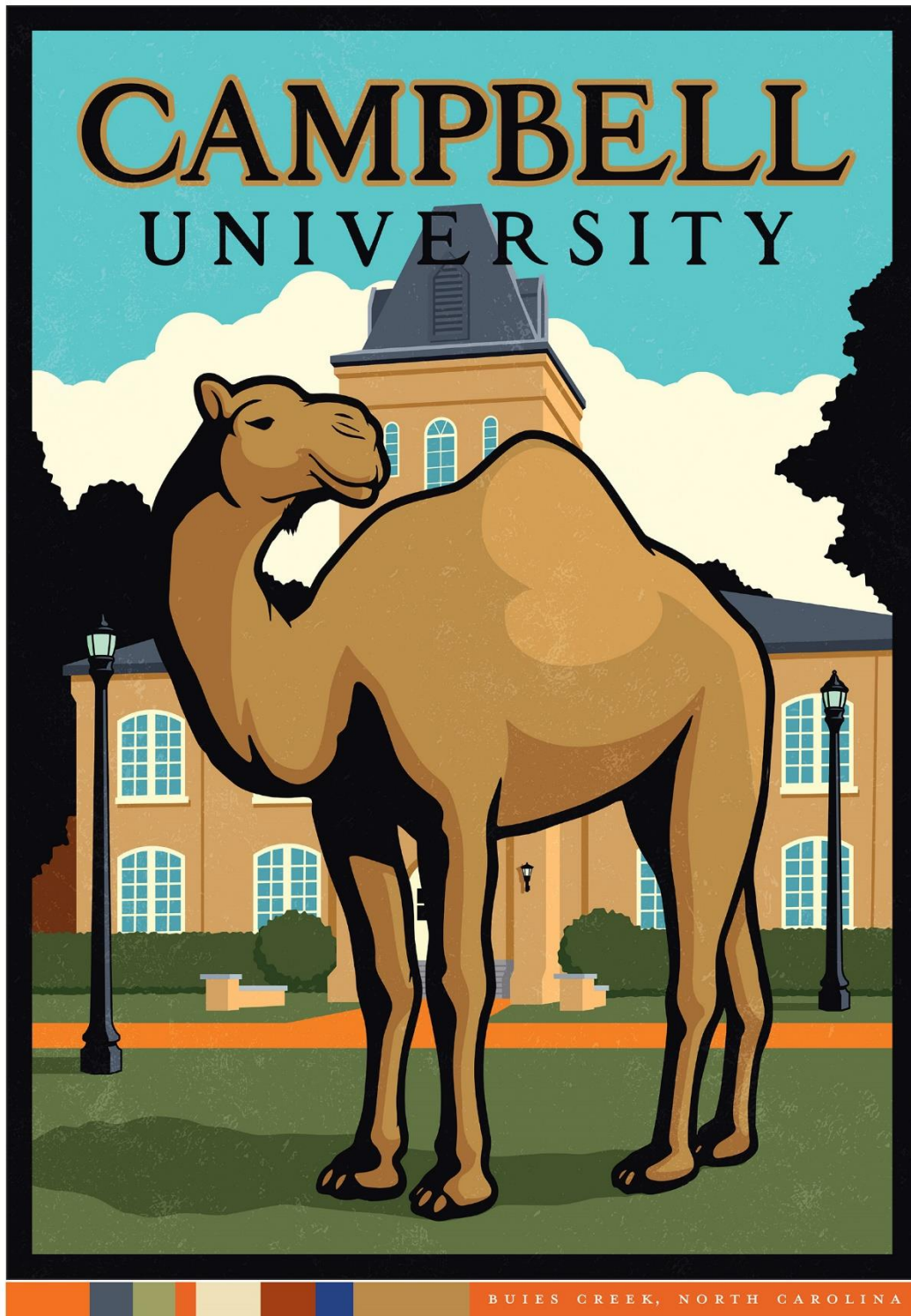


Table of Contents

Welcome 3

Medical..... 6

Supplemental Health 11

Spending Accounts..... 13

Dental..... 15

Vision 16

Life, AD&D, and Disability..... 17

Additional Benefits..... 19

Employee Resources 21

Important Notices 23



Welcome to Your 2024 Benefits

We are dedicated to providing you with unique benefits that meet the needs of you and your family. We understand the importance of a well-rounded benefits program, and because of that, we offer a range of plans that help protect you in the case of illness or injury. You can learn about the details of these plan options by reading through this Benefit Guide.

Starting with the basics of how to enroll, followed by the details of each plan, this guide is a go-to resource for all things benefits related. Once you understand the various options we offer, you can make an informed decision on which plans work best for you and your family.

We encourage you to read this booklet in its entirety. Included you will find details about:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit offered and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance
- And much more!

We appreciate the hard work and dedication you bring to our university. For this and many other reasons, we want to offer you competitive and cost effective benefits. It's one way we can say thank you for your contributions.

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact the Human Resources Department.

Sincerely,

Campbell University

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

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 questions about your benefits, contact Human Resources.

Eligibility & Enrollment

Who is Eligible

This booklet contains an overview of the benefit plans that are available to Campbell University full-time employees beginning plan year January 1, 2024. Elections you make during Open Enrollment will become effective January 1, 2024. All full-time employees (minimum 30 hours per week) are eligible for medical benefits on the first of the month, or first business day of the month. All other benefits begin on the first of the month following a 60-day waiting period from your hire date.

How to Enroll

To enroll in coverages for the 2024 plan year, log in to [Employee Navigator](#) and process your elections.

Open Enrollment will be held October 30th, 2023 to November 27th, 2023. Elections will become effective on January 1, 2024.

Coverage for 2023 will not automatically carryover to 2024 for FSA and HSA contributions. Each employee must review all benefits through Employee Navigator by November 27th, 2023.

How to Make Changes

Several benefits may only be elected or changed during open enrollment or with a qualified change in status. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

Please log in to Employee Navigator and update your information if any of the following situations occur:

- If your home address and/or phone number change
- If your marital status changes. HR will need the social security number and marriage license for any new marriages
- If your dependent children age off of the plan(s)
- If your spouse has a work status change and needs to be added to our plan
- If your beneficiaries need to be updated

Please contact one of the contacts below if you have a claim question you cannot resolve, or if you are disabled and/or need an extended absence from work due to health reasons (this includes you and/or immediate family members).

Human Resources Contacts

Deborah Ennis
(910) 893-1255
ennisd@campbell.edu

Or

Amy Emory
(910) 893-1699
emorya@campbell.edu

Or

Faith McCall
(910) 893-1256
fmccall@campbell.edu

Or

Trent Elmore
(910) 893-1635
telmore@campbell.edu

Or

Amber Fountain
(910) 814-4972
afountain@campbell.edu

Human Resources
Campbell University
PO Box 595
Buies Creek, NC 27506
(910) 814-4737 Fax

Medical & Prescription Drug Benefits

The chart below provides an overview of your available medical plans through Blue Cross Blue Shield of North Carolina (BCBSNC). Please refer to your plan document for specific details. Networks frequently change and so it is always a good idea to confirm your provider is in-network to avoid additional costs.

Find an in-network provider at www.blueconnectnc.com.

	Medical & Pharmacy Coverage	
Services	HDHP	PPO Plan
Deductible		
• Individual	\$3,250	\$1,250
• Family Member	\$5,500	\$1,250
• Family	\$5,500	\$2,500
Coinsurance		
• Plan Pays	80%	70%
• You Pay	20%	30%
Out-of-Pocket Max		
• Individual	\$5,250	\$4,500
• Family Member	\$8,900	\$4,500
• Family	\$9,500	\$9,000
Preventive Services	Covered 100%	Covered 100%
Primary Care	Covered 80% after deductible	\$30 copay \$5 copay at Campbell Health Center
Specialist Visit	Covered 80% after deductible	\$70 copay \$5 copay at Campbell Health Center
Telemedicine	Covered 80% after deductible	\$15
Urgent Care	Covered 80% after deductible	Covered 70% after deductible
Emergency Room	Covered 80% after deductible	Covered 70% after deductible
Inpatient Hospital	Covered 80% after deductible	Covered 70% after deductible
Prescription Drugs		
• Tier 1	Covered 80% after deductible	\$15 copay
• Tier 2	Covered 80% after deductible	\$30 copay
• Tier 3	Covered 80% after deductible	\$60 copay
• Tier 4	Covered 80% after deductible	25% to \$150
• Tier 5	Covered 80% after deductible	25% to \$200

Telemedicine

Your benefits anytime, anywhere with Teladoc! A telemedicine visit lets you see and talk to a doctor from your laptop or mobile device.

With this service, you can access care right away for non-emergencies and many other common illnesses.

By using telemedicine you can:

- Connect with a licensed doctor in minutes, by phone or video
- Skip the long waits and lines you'd experience going to the ER or Urgent Care
- Bypass the hefty medical bills you'd get going to the ER for non-emergencies

Common Treatable Issues

Telemedicine physicians can help treat non-emergencies like:

- Respiratory infections
- Allergies
- Bronchitis
- Cold & flu symptoms
- Skin problems
- Sinus problems
- & much more!

How to Get Started

Create your account so that when you need care, you can get it quickly. Download the Teladoc mobile app, visit www.teladoc.com or call 1-800-Teladoc.

Rally Health Program

Rally Health through BCBSNC is a health and wellness program that offers opportunities to participate in challenges and missions to improve or maintain your overall wellbeing. Access Rally Health from the BCBSNC home page, by clicking on the Wellbeing icon in the left side bar.

Rally Health begins with a health survey that is used to customize your experience in the program. Your health challenges and "missions" are tailored to areas that you want to focus on. Rally Health provides incremental goals to help you make positive changes in your life.

Know Where To Go

If you need immediate medical attention, your first thought may be to go to the Emergency Room. However, if your condition is not serious or life threatening, you may have a less expensive choice. Use the chart below to identify where you should go for care!

Plan	Cost	When to Use
Primary Care	\$	Routine, Primary, Preventive Care Regular Health Screenings Non-urgent treatment Chronic disease management
Telemedicine	\$	Cold, flu, fever, sore throat, diarrhea, rash, pink eye, sinus infections, cough, headache, stomachache or earache
Convenience Care	\$\$	Common infections (ear, pink eye, strep, bronchitis), flu shots, vaccines, rashes, screenings
Urgent Care	\$\$\$	Sprains, small cuts, strains, sore throats, minor infections, mild asthma, back pain or strain, vomiting, flu, fever, sports injuries <i>After hours care & no appointments necessary</i>
Emergency Room	\$\$\$\$	Heavy bleeding, large open wounds, chest pain, spinal injuries, difficulty breathing, major burns, severe head injuries, seizures, unconsciousness, poisoning <i>Life threatening emergency</i>

If you believe you are experiencing a medical emergency, go to your nearest emergency room or call 911, even if your symptoms are not as described here.

Your Cost for Medical Coverage

Your cost for medical coverage is deducted from each paycheck.

HDHP Employee Monthly Contributions				
	Wellness & Non-Smoker	Wellness & Smoker	Non-Wellness & Non-Smoker	Non-Wellness & Smoker
Employee Only	\$82.00	\$114.00	\$114.00	\$153.00
Employee + Spouse	\$415.00	\$523.00	\$523.00	\$555.00
Employee + Child(ren)	\$354.00	\$424.00	\$424.00	\$463.00
Employee + Family	\$590.00	\$783.00	\$783.00	\$821.00

PPO Plan Employee Monthly Contributions				
	Wellness & Non-Smoker	Wellness & Smoker	Non-Wellness & Non-Smoker	Non-Wellness & Smoker
Employee Only	\$99.00	\$133.00	\$133.00	\$174.00
Employee + Spouse	\$480.00	\$605.00	\$605.00	\$641.00
Employee + Child(ren)	\$464.00	\$531.00	\$531.00	\$572.00
Employee + Family	\$741.00	\$944.00	\$944.00	\$985.00

If an employee's spouse is eligible for medical coverage under their employer sponsored plan, the spouse is not eligible for coverage under the Campbell University medical and pharmacy plan.

Spousal Medical & Pharmacy Eligibility FAQs

1. What are the medical plan Spousal Eligibility rules?

If an employee's spouse is eligible for medical coverage under their employer sponsored plan, the spouse is not eligible for coverage under the Campbell University medical and pharmacy plan.

2. Why does Campbell University limit Spousal Eligibility for the medical plan?

For years, Medical and pharmacy claims costs for spousal coverage have continued rising at a rapid pace, and for this reason, Campbell University needs to limit spousal eligibility so that we may continue to offer quality insurance coverage at affordable rates for our employees.

3. Doesn't the Affordable Care Act (ACA) require employers to offer coverage to employees' spouses?

No. The ACA does not mandate employers offer health coverage to spouses of employees.

4. How will Campbell University know if my spouse is eligible for coverage with their employer?

Employees will answer several questions, and affirm their responses, when enrolling regarding whether or not their spouse is eligible for coverage under their employer sponsored plan.

5. Can I enroll my spouse in the dental, vision, voluntary life insurance and/or the Supplemental health plans?

Yes, your spouse is still be eligible for all other plans.

6. Can I still enroll my spouse on the Campbell University plan for secondary medical coverage?

No, you cannot enroll your spouse for medical coverage if they have access to another group medical plan through their employer.

7. If my spouse loses coverage due to this change in eligibility, will their employer's plan allow them to enroll if it is not an open enrollment period?

The loss in coverage would trigger a qualifying event, allowing the spouse's employer to enroll them in coverage. Spouses no longer eligible for the Campbell University medical plan should contact their Employee Benefits Department immediately concerning their enrollment procedures. Campbell University employees should contact their HR/Benefits team if additional documentation is requested for proof of loss of coverage.

8. Can I add my spouse if they lose coverage with their employer in the future?

Yes. The employee would have 30 days from loss of coverage date to add the spouse to our plan. Employees will need to provide proof of the loss of insurance coverage.

9. What do I need to do if my spouse begins a new job and their employer offers a medical plan?

It is the employee's responsibility to log-in to Employee Navigator and remove their spouse from the medical plan on the day their other medical coverage becomes effective. This change would be considered a qualifying life event and must be made within 30 days of the new medical coverage effective date. Employees will need to provide proof of the effective date of the new insurance coverage.



The Campbell University Health Center. Not just for runny noses! Come to the Health Center for all your primary care needs and orthopedic needs. Our staff physicians and nurses are here to help you with current health issues and preventive care to help you stay in good health! Need to get a prescription filled? Our Health Center pharmacy can do that for you too. You can contact the pharmacy at (910) 893-1400, the pharmacy is open Monday through Friday (times vary). You may also fill prescriptions at the Campbell Pharmacy for discounted medications!

Smoking Cessation. Campbell University continues to offer a free tobacco smoking cessation program at the Health Center. A non-smoking discount is automatically applied toward your monthly medical premiums. In order to continue receiving this discount, subscribers will be asked to either sign an attestation stating they are non-tobacco users, or sign up for the free Health Center program prior to 2/28/23 (or upon enrollment in medical insurance). Non-compliance will result in the loss of the non-smoker discount.

Diabetic Program. For years, Campbell University has offered Diabetes Management in the form of education and pharmacy assistance. This program will continue for 2024 and offers a free cellular enabled Accu-Check glucometer.

Campbell University is committed to helping you achieve optimal health and well-being.

Wellness Discount. A wellness discount is automatically applied toward your monthly medical premiums if you are enrolled in our wellness plan. To complete your Health Risk Assessment, you will need to register your account with BCBSNC. To receive the 2024 Wellness Discount you will have more time to meet the following criteria:

Step One: Complete a Biometric Screening or Annual Physical with the Health Center or your Physician between 01/01/2023 and 12/15/2023.

- If you have already completed your Biometric Screening or Annual Physical for 2023, you do not have to redo it for 2024.
- Obtain your screening for free at the Health Center, call 910-893-1561 for an appointment.
- Or visit your own provider for the cost of an office visit.

Step Two: Complete the BCBSNC Rally Health Survey between 01/01/2023 and 12/15/2023

- If you have already completed your Rally Health Survey in 2023, you do not have to redo it for 2024.
- Go to www.blueconnectnc.com to complete your Health Survey January 1, 2023 and December 15, 2023.

Wellness Benefit Included with Our Supplemental Health Plans

If you enroll in the Critical Illness, Accident, or Hospital Indemnity plan with Voya, you're eligible for an annual wellness benefit. Each plan member is eligible for this incentive one time per year.

You can earn your wellness benefit for getting a routine health screening – you're probably getting some of these tests already! Common screenings include:

- Blood test
- Mammogram
- Chest x-ray
- Colonoscopy
- Serum cholesterol test for HDL & LDL
- Stress test
- Pap smear
- Fasting blood glucose test

Supplemental Health Benefits

Supplemental Health

Campbell University knows that you value the opportunity to customize your insurance coverage to best fit your individual needs. We are pleased to offer the following voluntary plans from Voya to complement your medical plan.

Voluntary Accident Plan

Accident insurance can help protect you, your spouse, or your children from the unexpected expense of an accident. Voya's accident plan pays for accidents that happen to you on and off the job, 24 hours a day. Some of the common reasons for claims under this plan include broken bones, burns, and sports related injuries – including kids organized sports. There is no limit to the number of claims that can be filed.

This plan includes a **\$50 annual health screening benefit** paid annually to employee & spouse, \$25 for children, for having completed a covered health screen.

Benefit Highlights	
Dislocations	Up to \$10,000
Fractures	Up to \$10,000
Hospital admission	\$1,750

Accident Insurance Premium			
Employee Only	Employee & Spouse	Employee & Children	Employee & Family
\$15.04	\$24.62	\$28.77	\$38.35

Voluntary Critical Illness Insurance

Critical Illness insurance helps guard against financial hardship if you or a dependent is diagnosed with a covered condition. Some of the expenses this benefit can help pay include initial diagnosis, treatment, and follow-up care. This plan will pay you a lump sum cash benefit in the event you are diagnosed with a critical illness. This plan offers benefits for occurrence and re-occurrence of certain illnesses, and provides a heart rider that covers surgeries and invasive heart procedures. You can choose between a \$5,000, \$10,000 or \$20,000 benefit for employees. Coverage for spouses and children under 26 are also available.

Covered Illnesses Include:

- Invasive cancer
- Heart attack
- Stroke
- Paralysis
- End-stage kidney failure
- Major organ transplant

See benefit summary for all covered conditions. This plan also features a **\$100 annual health screening benefit** for employees and spouses, and a \$50 benefit for children.

Premium varies by age and benefit amount, see rates in Employee Navigator.

Voluntary Hospital Indemnity Insurance

The Hospital Indemnity plan provides a benefit for hospital admission and confinement for an illness or injury. The cash benefit is paid directly to you and can be used however you need. This plan includes benefit for initial admission, intensive care stays, and hospital confinement – including for maternity stays.

This plan also includes a **\$50 annual health screening benefit** per covered member.

Plan Features Include:

- Guarantee Issue at open enrollment, meaning no health questions are required to enroll in coverage!
- No pre-existing condition or waiting period; any hospital admission after 1/1/2020 will be covered
- Waiver of premium after 90 days of total disability due to a covered sickness or accidental injury for up to 12 months

Benefit Highlights	
Hospital Admission (per confinement)	\$1,500
Hospital Confinement (per day / max of 30 days per covered illness)	\$150
Hospital critical care unit (per day / max of 15 days per covered illness)	\$300
Rehabilitation facility (per day / max of 30 days per covered illness)	\$75

Hospital Indemnity Premium			
Employee Only	Employee & Spouse	Employee & Children	Employee & Family
\$24.77	\$47.93	\$40.51	\$63.67

Health Savings Account (HSA)

A HSA is a tax-advantaged account that you and your employer can put money into to save for future medical expenses and is yours to keep. HSA funds can be used to pay for eligible medical, dental and vision expenses.

Any adult can contribute to an HSA if they are covered under a HSA-qualified “high deductible health plan” (HDHP), do not have any other first-dollar medical coverage, are *not* enrolled in Medicare and are *not* claimed as a dependent on someone else’s tax return.

Your HSA is always yours, no matter what. Even if you leave the company, change health plans or retire. Unused money grows tax-free and can be invested with a minimum balance.

HSA Funding and Contributions:

Campbell University helps fund your HSA by matching your contributions. You must contribute at least \$250 for employee only coverage or \$500 for employee plus dependent coverage to receive a matching contribution.

The IRS imposes a maximum contribution limit to the HSA on a calendar year basis.

The 2024 maximums are:

- \$4,150 for individual
- \$8,300 for family
- \$1,000 catch up contribution for those 55 and older

Qualified Medical Expenses:

The IRS maintains a list of all eligible expenses, common qualified expenses include acupuncture, ambulance services, dental treatment, contact lenses, doctor’s fees and hearing aids.

View the complete list of qualified expenses at <https://www.irs.gov/publications/p502/index.html>.

Easy to Use:

Use your HSA debit card for qualified medical, dental, vision and prescription expenses. Your HSA funds can be spent for yourself and dependents!

Our HSA is now offered through Voya. Create an account at <https://myhealthaccount.voya.com> to easily manage your HSA.

Flexible Spending Accounts (FSA)

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. By anticipating your family's costs for the next year, you can actually lower your taxable income.

You must enroll in your FSA every year to contribute. Your FSA plan options are shown below.

Dependent Care FSA

- Allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders.
- **The annual contribution maximum is \$5,000** (or \$2,500 if married and filing separately).
- Examples of qualified expenses include:
 - Childcare
 - Before or after school program
 - Elder care
- Funds must be deducted from your paycheck before they are eligible to be used for reimbursement.

Healthcare FSA

- Allows employees who are not enrolled in an HDHP or contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars.
- **The annual maximum contribution of \$3,050 can be used for eligible health care related expenses, including medical, dental and vision expenses.**
- You can rollover a maximum of \$610 to the next plan year.
- Examples of qualified expenses include:
 - Prescriptions
 - Doctor visit copays
 - Contact lenses
 - Dental care
 - Certain over-the-counter products (feminine hygiene, pain relievers, etc.)
- Use your FSA debit card for qualified medical, dental, vision and prescription expenses.

Manage Your FSA

Create an account at <https://myhealthaccount.voya.com> to manage your FSA this year.

Dental Plans

The chart below provides an overview of your available dental plans, offered through Delta Dental. Please refer to your plan document for specific details. Using an in-network provider will offer you the lowest service pricing.

Find an in-network provider at www.deltadentalinc.com.

Benefits	Dental Plans	
	Low Plan	High Plan
Annual Deductible (Basic & Major Only)	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Preventive Services Exams, Cleanings, X-rays, Fluoride	Covered 100%	Covered 100%
Basic Services Fillings, Extractions, Anesthesia, Endodontics, Periodontics	80%	80%
Major Services Bridges, Full and Partial Dentures, Crowns, Inlays/Onlays	Not Covered	50%
Annual Maximum	\$1,000	\$1,250
Orthodontia	Not Covered	50% to \$1,000 Maximum

Your Cost

Your cost for dental coverage is deducted from each paycheck.

Monthly Employee Deductions			
	Employee Only	Employee + 1	Employee + Family
Low Plan	\$38.13	\$75.04	\$142.70
High Plan	\$40.49	\$79.69	\$151.56

Vision Plan

Campbell University will now offer a voluntary vision plan through EyeMed.

- ➔ If you are interested in vision coverage for yourself and/or your dependents, you will need to enroll in this new plan. Vision coverage will no longer be automatically provided for those enrolled in the medical plan.

Below is an overview of the benefits included with our plan. You have the freedom to choose any eye doctor, but you will pay less out of pocket when using an in-network provider.

Find an in-network provider at www.eyemed.com.

Vision Plan		
Services	Benefits	Frequency
Vision Exam	\$20 copay	Once every 12 months
Standard Lenses	\$20 copay	Once every 12 months*
Frames	Up to \$130 allowance, then you pay 80% of remaining balance	Once every 12 months
Contact Lenses Conventional	Up to \$130 allowance, then you pay 85% of remaining balance	Once every 12 months*
Disposable	Up to \$130 allowance, then you pay 100% of remaining balance	

*Lenses or contact lenses covered once every 12 months.

Your Cost

Your cost for vision coverage is deducted from each paycheck.

Monthly Employee Deductions			
	Employee Only	Employee + 1	Employee + Family
EyeMed	\$6.30	\$9.73	\$18.52

Basic Life and AD&D Insurance

Campbell University provides all full-time employees with Basic Life and Accidental Death & Dismemberment (AD&D) Insurance at no cost to you. Employees are automatically covered at 1x your annual earnings to a maximum of \$150,000. Benefits for this plan reduce by 65% at age 70, 50% at age 75.

Please make sure Employee Navigator has your designated beneficiary for this plan.

Voluntary Life and AD&D Insurance

Employees who want to supplement their group life and AD&D insurance benefits may purchase additional coverage through Voya. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions.

You can purchase voluntary life and AD&D insurance in the increments listed below.

Voluntary Life & AD&D Insurance	
Employee Coverage	<ul style="list-style-type: none">• Increments of \$5,000 up to 6x your annual earnings or \$500,000.• Guarantee Issue amount of \$150,000.
Spouse Coverage	<ul style="list-style-type: none">• Increments of \$5,000 up to \$250,000.• Guarantee Issue amount of \$25,000.
Child Coverage	<ul style="list-style-type: none">• Increments of \$2,000 up to \$10,000

Disability Insurance

Voluntary Short-Term Disability Insurance

Campbell University provides all full-time employees with the option to enroll in short-term disability coverage. Short-term disability coverage is available to you on a voluntary basis. Employees are responsible for the cost of coverage. To determine the monthly cost of this benefit, please log in to Employee Navigator.

Short-Term Disability			
	Option 1	Option 2	Option 3
Benefits Begin	31 st day accident / 31 st day illness	15 th day accident / 15 th day illness	1 st day accident / 8 th day illness
Benefit Duration	22 weeks	24 weeks	26 weeks
Income Replaced	60%	60%	60%
Maximum Benefit	\$1,500 / week	\$1,500 / week	\$1,500 / week

Long-Term Disability Coverage

Campbell University offers Long-Term Disability to all eligible employees through Voya and pays the full cost of this benefit. In the event you become disabled from a non-work related injury or sickness, this disability plan becomes a source of income to you.

Long-Term Disability	
Benefits Begin	After 180 days
Benefit Duration	To age 65 or Social Security Normal Retirement Age
Income Replaced	60% of monthly earnings
Maximum Benefit	\$2,000 per month

New! Voluntary Long Term Disability

Full-time employees can elect / receive employee paid long-term disability income benefits from Voya. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. Medical conditions treated within 3 months prior to the plan effective date are not covered for the first 12 months of coverage.

Voluntary Long-Term Disability	
Benefits Begin	After 180 days
Benefit Duration	To age 65 or Social Security Normal Retirement Age
Income Replaced	60% of monthly earnings
Maximum Benefit	\$5,000 per month

Additional Benefits

Tuition Assistance

Campbell University offers a range of tuition benefits to its full-time employees and their spouses and dependents for undergraduate and various program enrollees, in addition to some educational opportunities outside the University. Full-time employees are eligible for tuition benefits the following term after completion of the probationary employment period. Please check the personnel manual for details.

A dependent child of an eligible full-time employee is eligible for assistance if the employee is able to claim the child as a dependent on his/her federal income tax.

IDShield and LegalShield

As a Campbell University employee, you have the option of enrolling in IDShield or LegalShield products designed to help you protect your identity and provide legal assistance.

IDShield provides privacy monitoring of your name, social security number, email address, and other personal information as well as security monitoring to protect you financially. Comprehensive identity restoration is included. Individual and family coverage is available.

LegalShield offers access to our nationwide network of dedicated law firms. The benefit includes unlimited personal legal advice from attorneys, not paralegals, plus services including contract review, letters/phone

calls, will preparation, moving traffic violation court representation, civil trial defense, and more. Individual and family coverage is available.

For more information on these products, visit www.legalshield.com/info/campbelledu.

Employee Assistance Program

The Employee Assistance Program (EAP) offers confidential resources and referral services through ComPsych. This program is provided to you and your dependents at no cost by Campbell University.

The EAP provides assistance to you and your dependents on a variety of issues including:

- Relationship counseling
- Mental health counseling including depression and anxiety
- Work/life balance resources
- Family assistance including help finding childcare or elder care

Employees can take advantage of this resource with the full confidence that all information discussed with ComPsych will be kept confidential.

This program provides 3 confidential phone counseling sessions with experienced clinicians available to you 24/7. Call: 877.533.2363 TTY: 800.697.0353 or Online: guidanceresources.com Web ID: My5848i

Important Terms

Use the terms below to understand your benefits better!

Coinsurance	A percentage of a health care cost that the covered employee pays after meeting the deductible.
Copayment (Copay)	A fixed dollar amount for each doctor visit that the covered employee pays for a health care service, usually when the service is received. For example, a primary care doctor may charge a nominal copay per visit.
Deductible	A fixed dollar amount that the covered employee must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits for individual and other coverage tiers.
Explanation of Benefits (EOB)	A record of a person's past and current health events. A "detailed receipt." Ask for this whenever you have a medical service performed for your records. FSAs, HSAs and HRAs will sometimes need this additional verification.
Evidence of Insurability (EOI)	A questionnaire about the state of a person's health. Insurance companies use EOI questions to verify whether a person meets the definition of good health.
Guarantee Issue (GI)	A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, GI doesn't limit how much you can be charged if you enroll.
In-Network	Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
Out-of-Network	A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than in-network providers.
Out-of-Pocket Maximum	The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including copayments and coinsurance.
Preventive Care	Most health plans must cover a set of preventive services – like shots and screening tests – at no cost to you. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ to view free preventive services for all adults, women and children.
Premium	The amount the employee pays for your health insurance.

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources.

Benefit	Whom To Call	Phone Number	Website
Medical and Pharmacy	BCBSNC	877-258-3334	www.blueconnectnc.com
Dental	Delta Dental	800-662-8856	www.deltadentalnc.com
Vision	EyeMed	844-225-3107	www.eyemed.com
Supplemental Health Critical Illness Accident Hospital Indemnity	Voya	877-236-7564	www.pre-sents.voya.com/ERBC/CampbellU
Health Savings Account	Voya	833-232-4673	https://myhealthaccount.voya.com
Flexible Spending Account	Voya	833-232-4673	https://myhealthaccount.voya.com
Basic Life and AD&D Voluntary Life and AD&D	Voya	877-236-7564	www.pre-sents.voya.com/ERBC/CampbellU
Short-Term Disability Long-Term Disability	Voya	877-236-7564	www.pre-sents.voya.com/ERBC/CampbellU
Millennium Advisory Services	Financial Advisory	877-435-2489	www.mas-edu.com
IDShield and LegalShield	LegalShield	919-645-7020	www.legalshield.com/info/camp-belledu
TIAA	403(b)	800-842-2252	www.tiaa.org

2024 Benefits Video

To see a brief video review of our benefit offerings, click this link:

<https://www.brainshark.com/CampbellUniversity2024>

Educational Videos

Click on the videos below to learn more about how the benefit works.



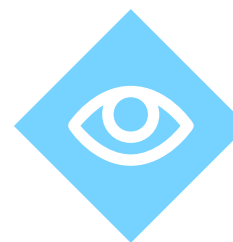
PPOs & HDHPs



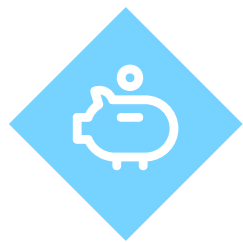
In & Out-of-Network



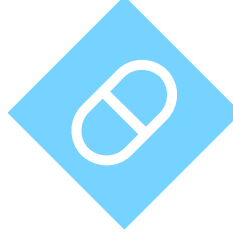
Dental



Vision



Health FSA



Health Savings Account



**Dependent Care
FSA**



EAP

Campbell University's Health and Welfare Benefits Annual Notice Packet

For the 2024 plan year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at (910)893-1255.

Medicare Part D Creditable Coverage Notice

Important Notice from Campbell University 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 Campbell University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Campbell University has determined that the prescription drug coverage offered by the 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 15th to December 7th. 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 while enrolled in Campbell University coverage as an active employee, please note that your Campbell University coverage will be the primary payer for your pre-

scription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Campbell University coverage as a former employee.

You may also choose to drop your Campbell University coverage. If you do decide to join a Medicare drug plan and drop your current Campbell University coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Campbell University 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 Campbell University changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit 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).

Name of Entity/Sender: Campbell University

Contact-Position/Office: HR Director

Address: 143 Main Street
PO Box 275
Buies Creek, NC - 27506
United States

Phone Number: (910)893-1255

HIPAA Special Enrollment Rights Notice

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

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.

Campbell University sponsors certain group health plan(s) (collectively, the “Plan” or “We”) to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Campbell University, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Campbell University, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Effective Date

This Notice as revised is effective October 11th, 2023

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however,

would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your

health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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 <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html> .

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

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

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

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

MONTANA - Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	NEBRASKA - Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000
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Email: HSHIPPPProgram@mt.gov	Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Women’s Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at (910)893-1255.

Newborns’ and Mothers’ Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

**** 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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.

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, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>. These rules are different for people with End Stage Renal Disease (ESRD).

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/agencies/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.

IMPORTANT NOTICES

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ Medicare Part D Cross-Reference
- ☐ Medicare Part D Non-Creditable Coverage Notice
- ☐ HIPAA Privacy Notice of Availability
- ☐ ACA Grandfathered Status Notice
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ EEOC Wellness Program Notice
- ☐ Surprise Billing Notice – “Your Rights and Protections Against Surprise Medical Bills”

IMPORTANT NOTICES

HIPAA Notice of Availability of Notice of Privacy Practices

The Campbell University's health plans maintain a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Deborah Ennis at (910)893-1255 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program

Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Deborah Ennis at (910)893-1255.

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

Protections from Disclosure of Medical Information

IMPORTANT NOTICES

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Deborah Ennis at (910)893-1255.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

IMPORTANT NOTICES

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
 - Cover emergency services by out-of-network providers.

IMPORTANT NOTICES

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to [learn more about protections from surprise medical bills](#) and for [contact information for the state department of insurance or other similar agency/resource in your state](#) to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

