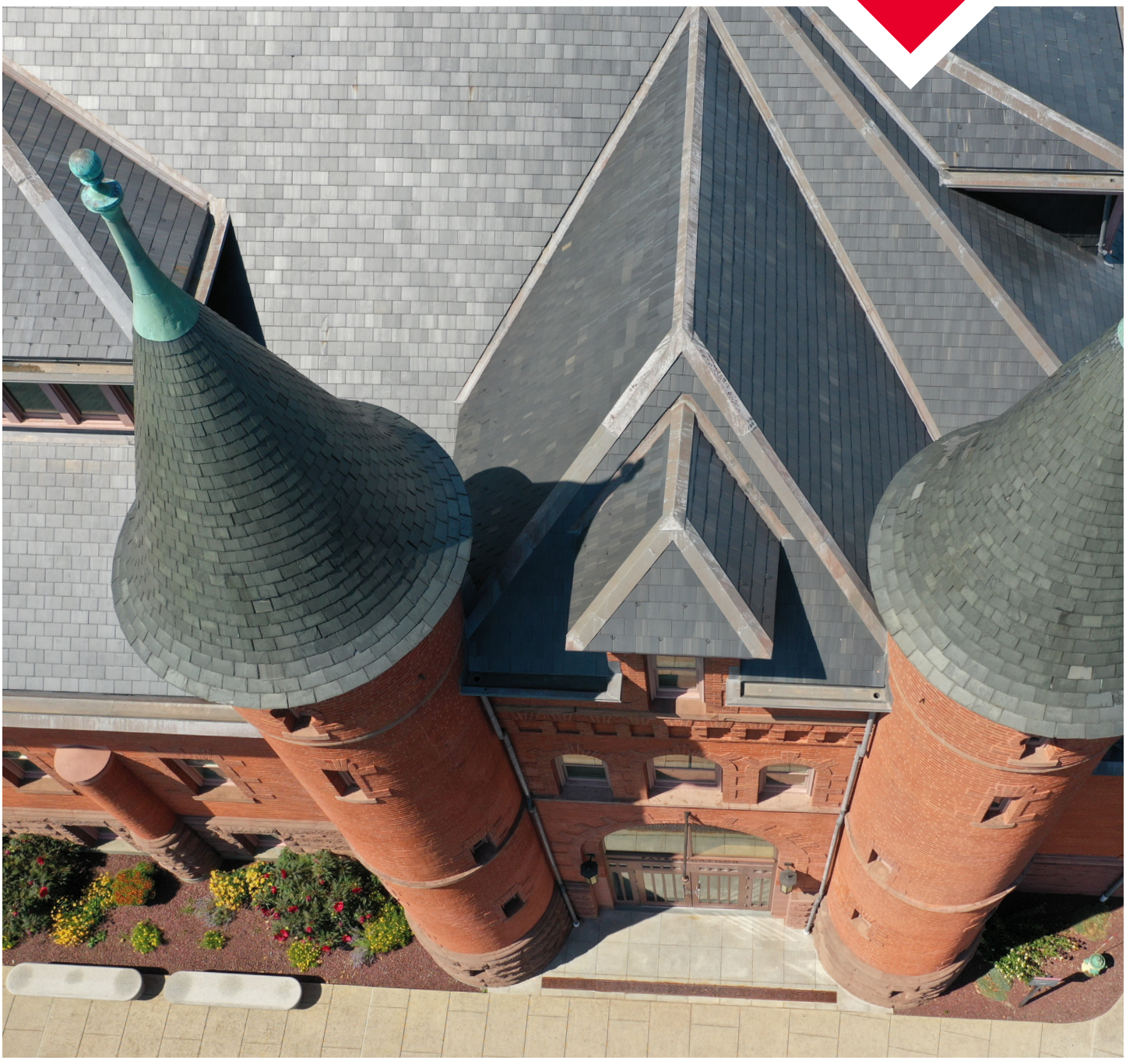
Wesleyan University

2023 BENEFITS GUIDE



Contents

New EAP Vendor!

BHS is the new provider of the Employee Assistance Program (EAP) for faculty, staff and their household members. EAP services are free to you, highly confidential and available 24/7/365. Please see page 26 for additional details.

Wesleyan University is committed to providing a comprehensive benefits program for its employees. This guide provides an overview of the benefits available to eligible employees and highlights any changes for the 2023 plan year.

Complete information on university benefits, including plan documents, is available at www.wesleyan.edu/hr.

Questions can be directed to Human Resources at benefits@wesleyan.edu.

Changes for 2023

- Medical premiums are increasing by 2%; however, dental, vision, and life insurance premiums are not increasing for 2023.
- All High Deductible Health Plan (HDHP) participants will receive an employer contribution into their Health Savings Account (HSA) whether or not they contribute their own pre-tax dollars into the account.
- Wesleyan HSA contributions for employee plus child(ren), employee plus spouse, and family will increase to $1,000. Employee only will remain at $500.
- The funding of Wesleyan's contribution to your HSA will take place as soon as possible after January 1, 2023 for funds to be available at the beginning of the plan year.
- One breast ultrasound will be covered per calendar year at 100% in-network, regardless of whether it is considered diagnostic or preventive by your provider. However, in the HDHP plan, the deductible will need to be met first for diagnostic testing as required by IRS regulations.

MONTHLY PREMIUMS

Effective January 1, 2023

Medical

	OAPIN		OAP		HDHP	
	Employee Cost	Wesleyan Cost	Employee Cost	Wesleyan Cost	Employee Cost	Wesleyan Cost
Employee	$249.25	$683.51	$294.57	$656.53	$186.17	$705.19
Employee + Spouse/Domestic Partner	$601.75	$1,636.89	$710.33	$1,572.30	$449.45	$1,689.81
Employee + Child(ren)	$474.71	$1,297.54	$560.51	$1,246.57	$354.36	$1,339.23
Family Including Spouse/Domestic Partner	$748.78	$2,049.51	$883.94	$1,969.34	$559.29	$2,114.80

- Employees can elect a medical plan without enrolling in the dental or vision plans.

2023 Premium Subsidy

Eligibility: Employees whose annualized full-time base salary is less than or equal to $68,666.

	Monthly Premium Subsidy
Employee	$69.24
Employee + Spouse/Domestic Partner	$149.03
Employee + Child(ren)	$149.03
Family Including Spouse/Domestic Partner	$183.69

Subsidy credits are applied to the employee paycheck based on pay frequency.

Dental Plan

	Core Plan		Buy-Up Plan	
	Employee Cost	Wesleyan Cost	Employee Cost	Wesleyan Cost
Employee	$14.73	$28.58	$20.33	$30.49
Employee + Spouse/Domestic Partner	$35.34	$68.60	$48.78	$73.18
Employee + Child(ren)	$27.98	$54.31	$38.62	$57.93
Family Including Spouse/Domestic Partner	$44.21	$85.82	$61.03	$91.55

EyeMed Vision*

Employee Cost
$4.71
$8.95
$9.42
$13.85

*100% employee paid.

- Employees can elect a dental plan without electing the medical or vision plans.
- Employees can elect the vision plan without electing the medical or dental plans.

Supplemental Life

Age	Employee Non-Smoker Monthly Rates (per $1,000)	Employee Smoker Monthly Rates (per $1,000)
0-24	$0.04	$0.05
25-29	$0.04	$0.05
30-34	$0.05	$0.06
35-39	$0.06	$0.07
40-44	$0.07	$0.09
45-49	$0.10	$0.15
50-54	$0.16	$0.23
55-59	$0.26	$0.38
60-64	$0.45	$0.65
65-69	$0.63	$0.92
> 69	$0.90	$1.30

- Employees may enroll in the Supplemental Life Insurance benefit at any time during the plan year. Please see page 22 for more details on this benefit.

ENROLLMENT INSTRUCTIONS

For Open Enrollment

The menu for 2023 Open Enrollment is in WesPortal under the "My Information" heading and labeled "Open Enroll 2023." If you are connecting to the network from an off-campus location, you will need VPN to access your Open Enrollment pages. Please use this link to view details on how to connect via VPN.

Log into the Open Enrollment site in WesPortal: after clicking on the initial page, you will enter the 2023 Open Enrollment page, titled "Benefit Elections as of 1/1/2023." You will be able to click each of the benefit areas to enroll or change your enrollment. **If you do not elect to make any benefit changes, your 2022 elections will roll over to 2023 with the exception of flexible spending and HSA accounts.**

Benefits for 2023

- Medical Benefits: Includes HSA election option if electing HDHP plan
- Dental Benefits
- Vision Benefits
- Life Insurance Benefits
- Short-Term Disability (STD)
- Long-Term Disability (LTD)
- Flexible Spending Accounts: Medical Expense Reimbursement Account (MERA) and Dependent Care Reimbursement Account
- Travel Assistance

How do I view and change dependent & beneficiary information?

- If you wish to update or add a dependent or beneficiary, please email benefits@wesleyan.edu. You will need to complete a Dependent/Beneficiary Enrollment Form and upload it to the Benefits secure drop box.

- If you do not wish to make any changes, your 2022 medical, dental, life insurance, and vision coverage will automatically be rolled over to 2023. Please check waive on the Open Enrollment page in WesPortal if you do not want medical coverage.
- FSA & HSA annual elections do not roll forward from one year to the next. You must make an election each year to be covered.

For New Hires

How Do I Enroll?

Please visit the Wesleyan Benefits site wesleyan.edu/hr which contains the information you need to review, select and securely upload your benefit enrollment options as a new employee of the University.

General Information

- Benefit elections and contributions are effective on your date of hire.
- You have 31 days from your date of hire to enroll in benefits. If you miss the window, the next opportunity to enroll will be during Open Enrollment (generally early November) or if you have a qualifying life event.
- Please make sure your address is accurate in WesPortal under Personal Information, especially if you recently moved. Insurance cards and important correspondence will be sent to that address.
- If you have questions about your benefit elections or uploading the form, please email benefits@wesleyan.edu. The address is monitored by all Benefits staff and allows us to answer your inquiries promptly.

ELIGIBILITY

Eligibility for medical, dental, vision, life insurance, health care savings accounts, flexible spending accounts, short-term disability, long-term disability, wellness points program, and travel assistance.

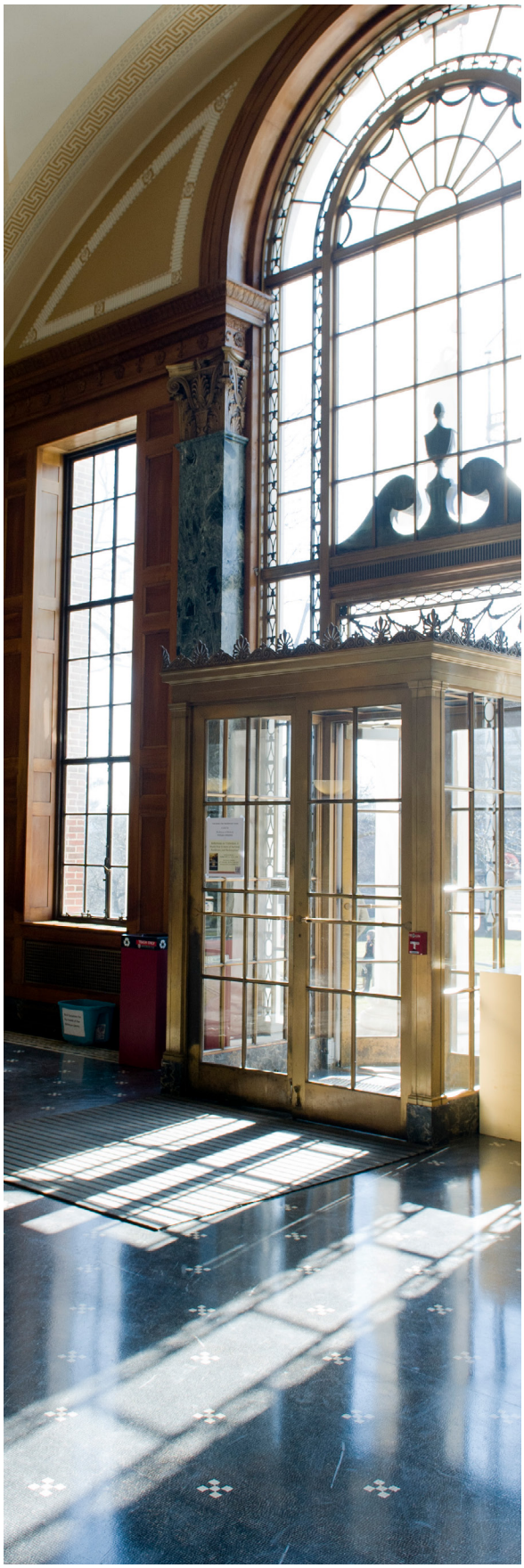
- Faculty members who work at least half-time (0.5 FTE or more)
- Administrative staff members and librarians who work at least half time (0.5 FTE or more)
- Bargaining unit members who work at least half time (0.5 FTE or more)
- Employees meeting eligibility under the Affordable Care Act (ACA) are eligible for medical coverage under the HDHP plan.

Dependent Eligibility

- Spouse
- Domestic Partner (mutual residence of six months and mutual financial support required)
- Children, including stepchildren and child(ren) placed for adoption who meet the IRS dependent definition
- Children the employee is legally obligated to support

Eligibility for retirement savings plans

- Faculty, staff, and bargaining unit members who work at least half time (0.5 FTE or more) and have appointments for more than one year are eligible for employer contributions and match (secretarial/clerical bargaining unit staff must have two years of service).
- Email benefits@wesleyan.edu to determine your eligibility and to enroll in the retirement plans.



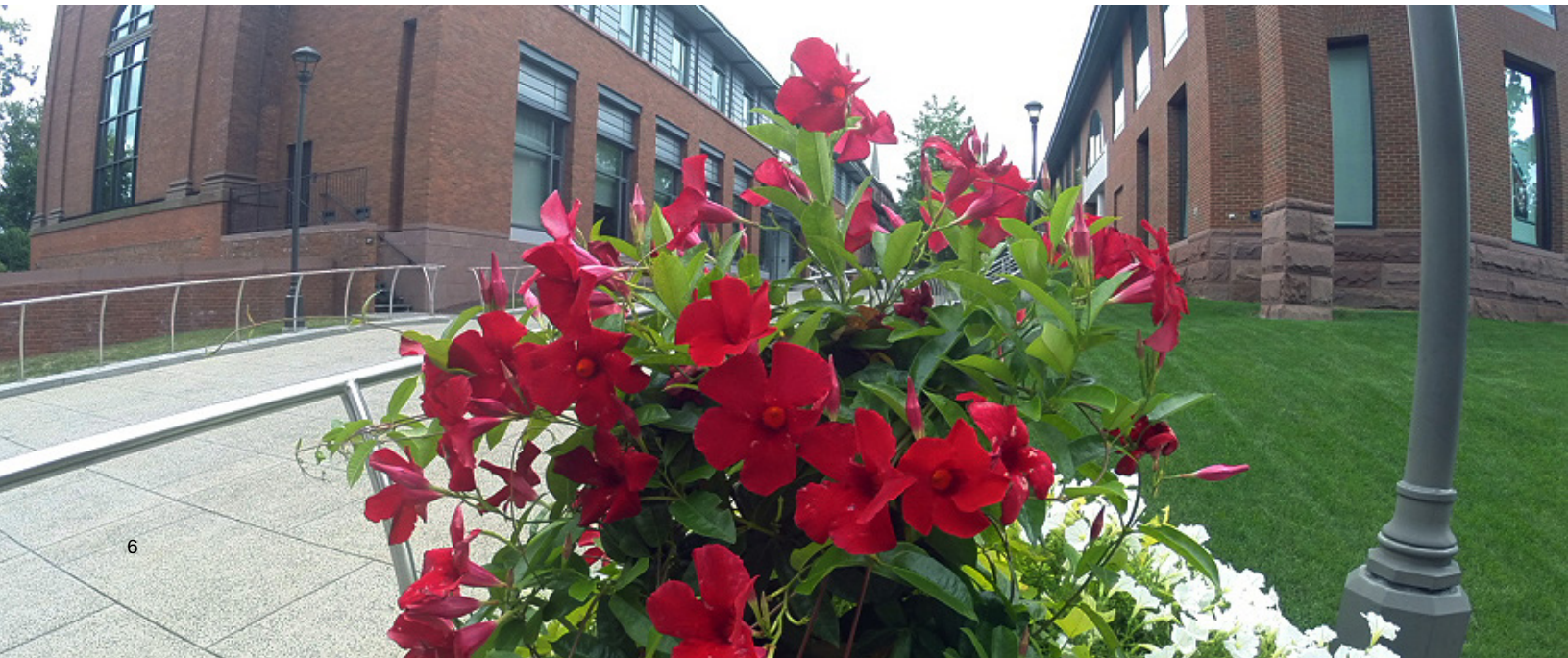
CHANGES TO ENROLLMENT

You may become eligible to change your benefits at any time during the year if you experience a qualifying life event. Examples of qualifying life events are marriage, death of a covered dependent, birth or adoption of a child, divorce or legal separation, loss or gain of coverage through a spouse's or domestic partner's employment, and a dependent's move into the state. A spouse's open enrollment period, if different from Wesleyan's, is also a qualifying event.

You have 31 days from the date of the event to make changes to your benefit plan(s); however, your changes and contributions will be effective on the qualifying event date. You must also provide documentation within that time frame.

- I have a qualifying life event, how do I make changes to my benefits?
  - By completing the Benefits Enrollment form and uploading the form, along with the documents supporting your qualifying life event to the secure drop box. For further instructions, please visit the Wesleyan Benefits website at wesleyan.edu/hr/staff/benefits/Enroll.html.
  - Remember: You have 31 days from the date of the event to make changes to your benefit plan(s).
- What documentation is required to support my qualifying event?

Qualifying Event	Documentation Accepted
Loss of coverage for your spouse/domestic partner	Letter from employer stating loss of coverage and reason(s) why ▪ Termination letter from employer or ▪ Termination letter from previous health plan
New coverage through your spouse/domestic partner	▪ Letter from spouse/domestic partner employer or ▪ Letter from spouse/domestic partner health plan
Marriage	▪ Marriage certificate
Newly qualifying domestic partner	▪ Domestic Partner Affidavit (form is located on the Benefits/ HR/Payroll Forms page of WesPortal)
Birth of child	▪ Birth certificate or Social Security Card
Adoption	▪ Adoption papers
Divorce or legal separation	▪ Filed court papers
Spouse/domestic partner's open enrollment	▪ Letter or documentation from spouse/domestic partner's employer



MEDICAL BENEFITS

- Cigna Open Access Plus High Deductible Health Plan (HDHP w/HSA)
- Cigna Open Access Plus — In-Network Only (OAPIN)
- Cigna Open Access Plus (OAP)

If you choose, you can open a Health Savings Account (HSA) when enrolling in the HDHP plan. To learn more about HSAs, please see page 15. If you are enrolled in the OAP or OAPIN plan, you are eligible to enroll in the Flexible Spending Account plan (MERA). To learn more about FSA accounts, please see page 17.

For more information on the medical plans offered by Wesleyan, please visit wesleyan.edu/hr/health-benefits/index.html

Here are some terms you will see in this guide:

Coinsurance: Your share of the costs of a health care service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've paid your plan's deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

Copay: A fixed amount you pay for a specific medical service (typically an office visit) at the time you receive the service. The copay can vary depending on the type of service. Copays cannot be included as part of your annual deductible, but they count toward your out-of-pocket maximum.

Deductible: The amount you pay for healthcare services before your health insurance begins to pay. For example, if your plan's deductible is $1,000, you'll pay 100% of eligible healthcare expenses until the bills total $1,000 for the year. After that, you may share the cost with your plan by paying coinsurance.

In-network: Care received from a doctor, group of doctors, clinics, hospitals, or other health care providers that have an agreement with your medical plan provider. You'll pay less when you use in-network providers.

Out-of-network: Care received from a doctor, group of doctors, clinics, hospitals, or other health care providers that do not have an agreement with your medical plan provider. You'll pay more when you use out-of-network providers. Some plans only allow out-of-network care in urgent or emergent situations.

Out-of-pocket maximum: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

Prior Authorization: Cigna will review information from your doctor to make sure you meet coverage guidelines for a test or procedure. If approved, your plan will cover the test or procedure.

Reasonable and customary: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.

MEDICAL AND PRESCRIPTION DRUG PLAN SUMMARY

Medical	OAPIN		OAP		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible* Employee only Family coverage	 $500 $1,000	 Not covered	 $500 $1,000	 $750 $1,500	 $1,500 $3,000†	 $1,500 $3,000†
Coinsurance**	0%	Not covered	0%	30%	0%	20%
Out-of-pocket maximum (includes deductible) Employee only Family coverage	 $1,500 $3,000	 Not covered	 $1,500 $3,000	 $2,500 $5,000	 $3,000 $6,000†	 $3,000 $6,000†
Preventive care	No charge	Not covered	No charge	30% after ded.	No charge	20% after ded.
Office visit (PCP and specialist)	$25/$35	Not covered	$25/$35	30% after ded.	0% after ded.	20% after ded.
Emergency room	$200	Not covered	$200		0% after ded.	
Urgent care	$40	Not covered	$40		0% after ded.	
Inpatient care	Deductible	Not covered	Deductible	30% after ded.	0% after ded.	20% after ded.
Outpatient care	Deductible	Not covered	Deductible	30% after ded.	0% after ded.	20% after ded.
Telehealth	$25 or $35 depending on service	Not covered	$25 or $35 depending on service	Not covered	0% after ded.	Not covered
Eye Exam	$0	$75 reimbursement	$0	$75 reimbursement	$0	$75 reimbursement
Lab & Radiology	Deductible	Not covered	Deductible	30% after ded.	0% after ded.	20% after ded.
Prescription Drugs	**OAPIN**		**OAP**		**HDHP**	
Retail (30-day supply)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Tier 1 — Generics	20% with $5 min/$50 max	Not covered	20% with $5 min/$50 max	Not covered	20% with $5 min/$50 max after ded.	Not covered
Tier 2 — Preferred	25% with $15 min/$50 max	Not covered	25% with $15 min/$50 max	Not covered	25% with $15 min/$50 max after ded.	Not covered
Tier 3 — Non-Preferred	25% with $20 min/$50 max	Not covered	25% with $20 min/$50 max	Not covered	25% with $20 min/$50 max after ded.	Not covered
Designated Retail Sites or Mail Order (90-day supply)						
Tier 1 — Generics	20% with $10 min/$100 max	Not covered	20% with $10 min/$100 max	Not covered	20% with $10 min/$100 max after ded.	Not covered
Tier 2 — Preferred	25% with $30 min/$100 max	Not covered	25% with $30 min/$100 max	Not covered	25% with $30 min/$100 max after ded.	Not covered
Tier 3 — Non-Preferred	25% with $40 min/$100 max	Not covered	25% with $40 min/$100 max	Not covered	25% with $40 min/$100 max after ded.	Not covered

1. Depending on service
**Coinsurance percentage represents amount of employee's responsibility.
† There is no individual limit built into the family deductible or out-of-pocket maximum.

*For OAP and OAPIN plans, deductible only applies to the following:

- Inpatient & Outpatient Services and Procedures
- Laboratory
- Radiology
- Advanced Imaging (MRI, CT, etc)
- Home Healthcare
- Durable Medical Equipment
- Prosthetic Devices/Wigs
- Hearing Aids
- Gene Therapy
- Skilled Nursing (OAP only)

For the OAP plan, the deductible and out-of-pocket maximum do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out- of-Network will accumulate to Out-of-Network).

For the HDHP plan, the deductible and out-of-pocket maximum cross-accumulate (that is, the amount paid for all covered expenses counts toward both the In-Network and Out-of-Network deductibles and out-of-pocket maximums).

One diagnostic or preventive breast ultrasound per calendar year will be covered in-network at 100% under the OAPIN and OAP plans. PLEASE NOTE: In order for your claim to be covered at 100% by the HDHP plan, your provider must use the appropriate preventive codes.

PHARMACY BENEFITS

Cigna 90 Now

Wesleyan medical plans include a maintenance medication program called Cigna 90 Now.

- If you choose to fill your prescription with a 90-day supply, you must use a 90-day retail pharmacy in your plan's network. You can also use the Cigna Home Delivery Pharmacy. **Important Note:** Please confirm the pharmacy network for your 90-day fills. Visit Cigna's 90 Now page for more information.
- If you choose to fill your prescription with a 30-day supply, you can use any retail pharmacy in your plan's broader network.

Where you can fill a 90-day prescription

With Cigna 90 Now, your plan offers a retail pharmacy network that limits where you can fill your 90-day prescriptions. You will still have access to a robust network of providers. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop! If you prefer the convenience of having your medications delivered to your home, you can also use Cigna Home Delivery Pharmacy to fill your prescriptions. For more information about your new pharmacy network, visit Cigna's 90 Now page.

Value Drug List

To see a current list:

1. Visit myCigna.com
2. Once you're registered, log in and select **Estimate Health Care Costs**
3. Select **Get Drug Costs.**

You can also view your drug list at Cigna.com/druglist and select your drug list name "Value 3 Tier" from the drop down menu.

- Certain brand name drugs that are also available over-the-counter will be dispensed as a generic drug only (for example, drugs to treat acid reflux).
- Pre-authorizations are needed for specialty drugs. Your provider's office will coordinate this with Cigna at the time you are given a prescription.

Questions?

Call the toll-free number on the back of your Cigna ID card. You can also chat with Cigna online on myCigna.com, Monday–Friday, 9:00 am–8:00 pm EST.

Wesleyan's group number is **3188492**.

Common Pharmacy Terms

Prior Authorization (PA) – Cigna will review information your doctor provides to make sure you meet coverage guidelines for the medication. If approved, your plan will cover the medication.

Step Therapy (ST) – Certain high-cost medications are part of the Step Therapy program. Step Therapy encourages the use of lower-cost medications (typically generics and preferred brands) that can be used to treat the same condition as the higher-cost medication. These conditions include – but are not limited to – depression, high blood pressure, high cholesterol, skin conditions, and sleep disorders. Your plan doesn't cover the higher-cost Step Therapy medication until you try one or more alternatives first (unless you receive approval from Cigna).

Quantity Limits (QL) – For some medications, your plan will only cover up to a certain amount over a certain length of time (for example, 30 mg per day for 30 days). Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna.

MEDICAL PLAN FREQUENTLY ASKED QUESTIONS

Which services are subject to the annual deductible under the Open Access Plus and Open Access Plus In-Network plans?

The Wesleyan Open Access Plus and Open Access Plus In-Network plans have an annual deductible of $500 for individuals and $1,000 for families.

The following services fall under this deductible:

- Lab work
- Imaging (x-ray, MRI, PET, CT and ultrasound)
- Durable medical equipment
- Inpatient procedures and services
- Outpatient procedures and services
- Home healthcare
- Prosthetic devices
- Hearing aids
- Gene Therapy
- Skilled Nursing (OAP Plan)

Once the deductible is met, these services are covered at 100% for the rest of the plan year.

The deductible also counts toward your annual out-of-pocket maximum.

I went for a preventive procedure and expected to pay nothing. Why am I being billed?

All preventive services that are coded as preventive are covered at 100%. A diagnostic procedure is subject to the applicable deductible and copay. Make sure you talk with your provider about the procedure so you know how it is being billed.

I am turning 65 but am not planning to retire yet. Do I have to terminate from Wesleyan's benefits and apply for Medicare Parts B and D? What about my spouse/partner?

As long as you are an active, benefit-eligible employee, you and your spouse/partner may remain on the Wesleyan benefit plan regardless of age.

I have questions about my medical bill. Who should I contact?

Call Cigna at 1-800-244-6224 and log into your myCigna.com portal to look up the date of service correlating to the bill. Many times, bills are sent by the provider before Cigna has fully processed the claim. Always check your Explanation of Benefits (EOB) to see how the claim is being processed. A representative at Cigna is available to help you resolve any eligibility or claim issues you have.

Cigna denied a prescription my doctor wants me to have. I have tried other therapeutic equivalent drugs but have medical challenges and can only take this one drug. What should I do?

Your doctor should be able to help you with an appeal to Cigna. If you have a medical need, they should be able to document this with Cigna to help with an approval. Have your providers' office contact Cigna to initiate the process for you.

I am getting married! How can I add my spouse to my plan?

See page 6 for information on qualifying life events and how to make changes to your benefits.

My doctor wants me to get an MRI (or other procedure) yet Cigna sent me a letter of denial. What should I do?

Call Cigna at 1-800-244-6224 to have someone walk through the denial with you. It is important to receive clarification.

In many cases of denied authorizations, the treating provider did not submit all of the necessary medical documents needed for an approval.

By calling Cigna and engaging with your provider you should be able to resolve the issue.

ADDITIONAL PROGRAMS AND RESOURCES THROUGH CIGNA

Cigna Lifestyle Management Program

Whether your goal is to lose weight, quit tobacco, or lower your stress levels, Cigna lifestyle management programs can help – and at no additional cost to you! Each program is easy to use and available where and when you need it. You can use each program online or over the phone – or both.

To sign up for any of the lifestyle management programs, visit myCigna.com or call 800-Cigna24.

Weight Management Reach your goal of maintaining a healthy weight. Create a personal healthy-living plan that will help you build your confidence, be more active, and eat healthier. You'll get the support you need to stick with it.

Tobacco Cessation Get the help that you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. Get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum).

Stress Management Get help lowering your stress levels and raising your happiness levels. Learn what causes you stress and develop a personal stress management plan. Get the support you need to help you cope with stressful situations – both on and off the job.

Patient Assurance Program through Cigna

Managing diabetes is not easy, but this program helps control the cost of eligible insulin products making them more affordable. A 30-day (or one month) supply costs no more than $25 and a 90-day (or three month) supply costs no more than $75.

- Basaglar
- Humalog
- Humulin
- Levemir

Additional insulin products may be included in the program. If you're currently taking an insulin that is not included in the program, talk with your doctor about whether taking an insulin covered under the program is right for you. Only you and your doctor can decide what's best for you.

Cigna One Guide

Whether you're a current Cigna customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. We want to help by providing the resources you need to make a decision with confidence. That's why One Guide is available to you:

Before Enrollment

Call a Cigna One Guide representative before you enroll to get personalized, useful guidance. Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.

After Enrollment

After enrollment, the support continues for Cigna customers. Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills
- Connect to clinical programs, lifestyle coaching and behavioral health services

Cigna Total Behavioral Health Program

Many physical conditions can worsen with stress, substance abuse and other behavioral health issues. Cigna Total Behavioral Health is a comprehensive program that provides dedicated support, lifestyle coaching, and online tools to help you manage life events.

Virtual Behavioral Care

Use your smartphone, tablet or computer for online video conferencing. Your out-of-pocket cost is the same as a behavioral health outpatient office visit. Refer to your plan documents for costs and details of coverage.

To find a Cigna network provider, visit myCigna.com, go to "Find Care & Costs" and enter "Virtual Counselor" under "Doctor by Type".

happify™

Everyday stressors can impact your relationships, work, health, and emotional well-being. Cigna has partnered with happify, a free app with science-based games and activities that are designed to help you defeat negative thoughts, gain confidence, reduce stress and anxiety, increase mindfulness and emotional well-being, and boost health and performance.

Sign up and download the free app at happify.com/cigna.

iPrevail

Learn how to boost your mood and improve mental health with on-demand coaching that is available 24/7. After completing a brief assessment, you will receive a program tailored to your needs that includes interactive lessons and tools. You get access to a peer coach who is matched based on your symptoms. You can also join support communities focused on stress, anxiety, depression, and more. Sign up on myCigna.com.

Please note, all behavioral health visits, telehealth visits and Ginger consultations require cost sharing as per the behavioral health visits described in the chart on page 8.

Ginger

Incredible mental healthcare when you need it

Everyone deserves access to incredible mental healthcare. That's why Ginger created the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It's like a virtual clinic without the waiting room. Ginger's mental health services are in-network and accessible through your behavioral health benefits.

What is Ginger?

Ginger offers confidential mental healthcare through behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry. Support is available anytime (24/7/365), anywhere (we go where your phone goes), for a variety of mental health challenges you may be struggling with—all from the privacy of your smartphone.

How do I begin chatting with a Ginger behavioral health coach?

Download the Ginger emotional support app from your smartphone. Follow the instructions sent to your email. Enter your: First name, last name, date of birth and your Member ID number to verify your eligibility. Then, answer a few questions, and you're ready to get started! Choose to schedule an appointment with your coach at a time that works best for you, or chat right away.

What kinds of things can a Ginger coach help me with?

With a behavioral health coach, anyone can get personalized support to help overcome life challenges and reach goals in their moment of need. Coaches can help with any issue you're struggling with such as stress, anxiety, depression, issues with work, relationships, sleep, and more.

TELEHEALTH

Cigna Telehealth Connection provides care — including most prescriptions — for a wide range of minor conditions. Patients can connect with a board-certified doctor when, where, and how it works best for them — via video or phone — without having to leave home or work.

Choose when - Day or night, weekdays, weekends, and holidays.

Choose where - At home, at work, or on the go.

Choose how - Phone or video chat.

Speak with a doctor who can help with:

- Sore throat
- Fever
- Cold and flu
- Allergies
- Headache
- Behavioral/mental health
- Rash
- Preventive care

MDLIVE televisits can be an affordable alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit to a primary care provider.

MDLIVE

- Consultations may be initiated through myCigna.com or by calling 888-726-3171.

Virtual Wellness Screenings through MDLIVE

Simply make your appointment online and go for a quick visit to a lab for your blood work and biometrics. The rest is completed online and via video or phone, wherever it's most convenient for you.

Step 1. Complete your MDLIVE online health assessment.

Step 2. Choose an in-network lab and schedule an appointment.

Step 3. Choose an MDLIVE provider and schedule your virtual visit.

Step 4. Go to your lab appointment. You'll receive a notification when the results are available in the MDLIVE customer portal.

Step 5. Attend your virtual visit from anywhere via video or phone. You will receive a summary of your screening results for your records.

Get started with your virtual wellness screening by visiting myCigna.com and choosing the "Talk with a doctor or nurse 24/7" callout box and click "Connect Now." Virtual wellness screenings are covered at 100% as part of your preventive care benefits.

What MyCigna can do for you

Using myCigna.com or the myCigna app you can personalize, organize, and access your important plan information on your computer, phone, or tablet.

- Manage and track claims
- View ID card information
- Find in-network doctors and compare cost and quality ratings
- Review your coverage
- Track your account balances and deductibles
- Refill your prescription drugs online
- Compare prescription drug prices at network pharmacies
- Connect to clinical, lifestyle coaching, and behavioral health services

Cigna Health Matters Care Management Program

If you or a loved one are faced with a medical condition, it's understandable to feel overwhelmed. Cigna's care management programs are in place to support you at every step of your journey toward better health.

What is Care Management?

Care management is a collaborative process of helping to find the right services to meet your family's comprehensive health needs. Cigna's nurse advocates help manage your care by bringing together the right resources and people to meet your needs. Cigna has social workers, pharmacists, and behavioral health professionals who are ready to help. These services are available at no additional cost to you and are completely confidential.

Guidance

- Helping you understand your coverage and out-of-pocket costs.
- Guiding you to resources that go beyond medical treatment, such as support for chronic conditions.
- Helping you take advantage of myCigna.com, where you can access a variety of health and wellness tools and resources.

Coordination

- Partnering with your health care providers to help you manage your overall care plan.
- Coordinating referral, home care, durable medical equipment (DME), caregiver respite services, and more.
- Identifying resources, such as transportation to appointments or financial assistance programs.

Support

- Helping you understand your condition, treatment options and medications.
- Providing the support you need for your physical, emotional, and financial well-being.
- Answering your questions and addressing your concerns.
- Your nurse case manager may reach out to you or you may inquire about care management by calling member services at 800-244-6224.

Cigna Clinical Management Programs

Your Health Matters Chronic Condition Management

If you have a chronic health condition, you'll develop a one-on-one relationship with a dedicated health advocate to help you manage chronic conditions ranging from asthma and low back pain to depression and coronary artery disease, among many others.

Your dedicated health advocate will help you:

- Obtain information and resources about your condition
- Create a plan to help improve your health (based on your goals)
- Understand medications and doctor's orders
- Make more educated decisions about your health and treatment options

To initiate a confidential, one-one-one conversation, call 800-244-6224 or visit myCigna.com.

Cancer Support Program

Whether you have cancer – or are a cancer survivor – you can get one-on-one support to help you with everything from understanding your diagnosis to discussing your health care provider's treatment to celebrating your survivorship.

Your personal nurse advocate will help you:

- Address immediate needs and concerns
- Understand your diagnosis, medications, and treatment options
- Coordinate follow-up care and screenings
- Understand your health plan benefits and find quality providers in your area
- Find quality local support groups and facilities
- Manage post-cancer care and support

For additional information, call 800-615-2909 or visit myCigna.com.

Healthy Babies Program

Cigna's Healthy Babies prenatal care and education materials provide information and support – from prenatal to post-delivery.

Get help throughout your pregnancy:

- Maternity specialists are available over the phone 24/7 to help you with everything from morning sickness to maternity benefits.
- Support from a case manager if you're hospitalized during your pregnancy or if your baby is in the NICU. Download the Cigna Healthy Pregnancy app to track and learn about your pregnancy.
  The app also provides support for the baby's first two years.

For additional information, call the number on the back of your Cigna ID card.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pre-tax dollars.

You own and administer your HSA. You determine how much you contribute to your account, when to use your money to pay for qualified medical expenses, and when to reimburse yourself. Remember, this is a bank account; you must have money in the account before you can spend it.

HSAs offer the following advantages:

Tax savings: You contribute pre-tax dollars to the HSA. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for medical expenses.

Reduced out-of-pocket costs: You can use the money in your HSA to pay for eligible medical expenses and prescriptions. The HSA funds you use can help you meet your plan's annual deductible.

A long-term investment that stays with you: Unused account dollars are yours to keep even if you retire or leave the University. Also, you can invest your HSA funds, so your available healthcare dollars can grow over time.

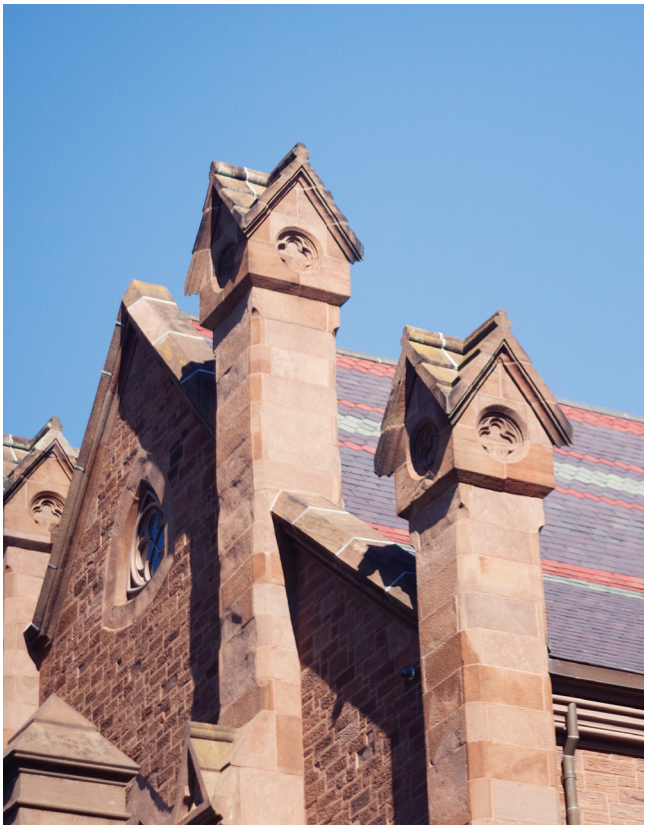
You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible high-deductible health plan, such as Wesleyan's HDHP plan.
- You are not covered by your spouse's non-HSA eligible medical plan, health care flexible spending account (FSA), or health reimbursement account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return. Dependents over age 19 (or age 23 if full-time student) must open and fund their own HSA).
- You are not enrolled in Medicare Part A, B or D, TRICARE, or TRICARE for Life.
- You have not received Veterans Administration Benefits in the last three months.

How to access/make contributions to your HSA

Once your account is open, you can access it via myCigna.com by clicking on "Visit your HSA bank to manage your account." You'll set up your payroll contributions during open enrollment. You can make contribution changes at any time during the year. The HSA contribution form is located on the benefits/HR/payroll forms page on WesPortal.

Note: It may take between one and two payroll periods for an HSA change to be processed.



More details about Health Savings Accounts

The HSA is administered by HSA Bank. Wesleyan pays the monthly administrative fee for your HSA. If your coverage status or employment status changes, you will be responsible for all HSA account holder fees.

You'll notice two separate line items on your paycheck when you participate in the HDHP with HSA option – one for your employee premium for the HDHP and one for your pre-tax contributions to the HSA.

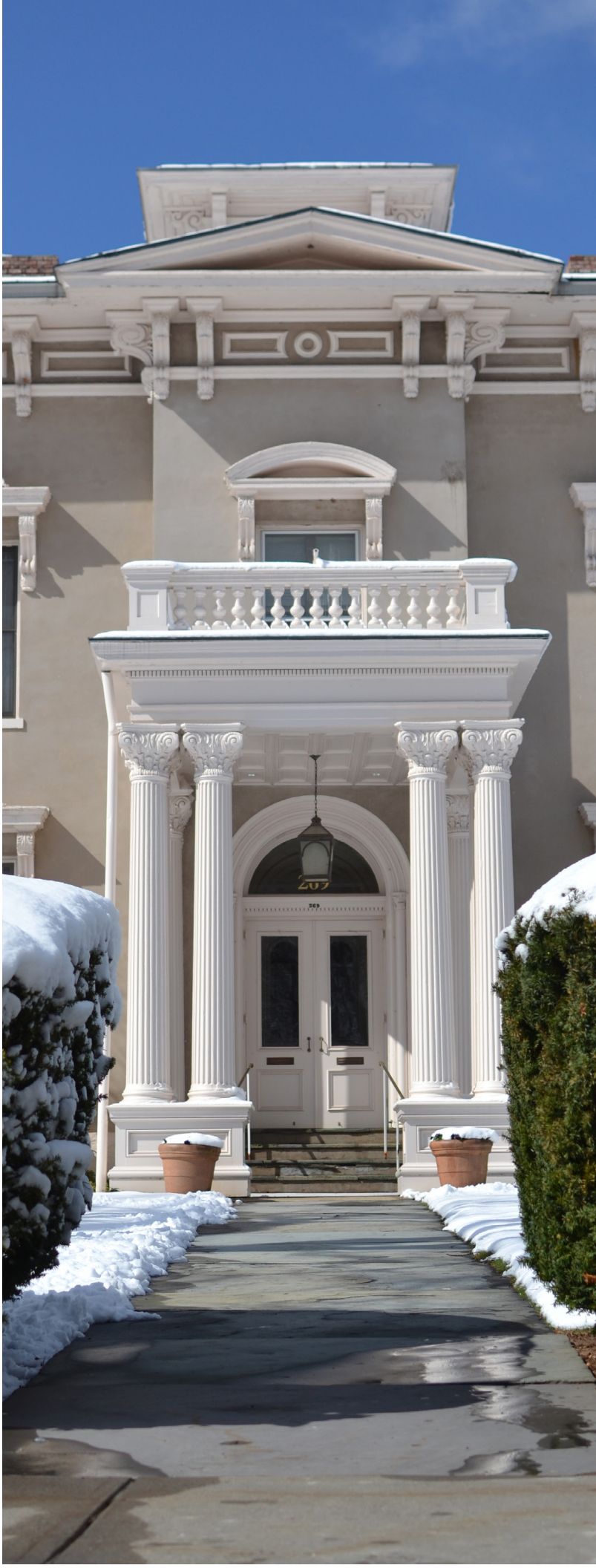
2023 IRS Annual Contribution Maximums	
Individual Coverage	$3,850
Family Coverage	$7,750
Age 55+	(not enrolled in Medicare) Contribute an additional $1,000

2023 Wesleyan Contributions

NEW FOR 2023!

- All HDHP participants will receive an employer contribution into their Health Savings Account (HSA), whether or not they contribute their own pre-tax dollars to the account.
- Wesleyan HSA contributions for employee plus child(ren), employee plus spouse (or domestic partner), and family will increase to $1,000. Employee only will remain at $500.
- The funding of Wesleyan's contribution to your HSA will take place on or as soon after January 1, 2023 as possible for funds to be available at the beginning of the plan year.

***IMPORTANT! Wesleyan's contributions count toward the IRS annual maximum.**



FLEXIBLE SPENDING ACCOUNT (FSA)

Medical Expense Reimbursement Account (MERA)

This plan allows you to pay for eligible out-of-pocket expenses with pre-tax dollars. Eligible expenses include plan deductibles, copays, coinsurance, and other non-covered medical, dental, and vision healthcare expenses for you and your dependents.

Dependent Care FSA

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, pre-school, and before and/or after school care for your dependent children under age 13 (other individuals may qualify if they are incapable of self-care and are considered your taxable dependents).

Please note: All caregivers must have a tax ID or Social Security number, which must be included on your federal tax return. If you use the Dependent Care FSA, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your professional tax advisor to determine whether you should enroll in this plan.

	MERA/Dependent FSAs
MERA - Plan Year Maximum	$3,050
Dependent Care FSA - Plan Year Maximum	$5,000 ($2,500 if married and filing separately)
Grace and Run-Out Periods	For 2023, you can incur expenses through March 15, 2024 as long as you submit them for reimbursement to GDI by April 15, 2024.

Group Dynamic, Inc. (GDI) Dashboard

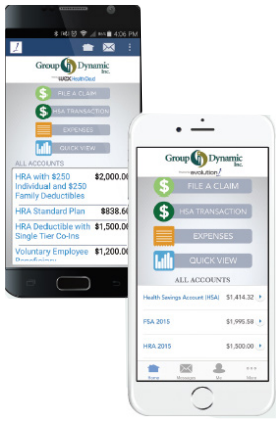
GDI's portal gives you easy, secure access to your accounts whenever you need it.

Get Started

Go to www.gdynamic.com and click on "Participants" under the "Log In" menu at the top of the screen. Enter your Username and Password, or click on "Create your new username and password" if you are logging in for the first time.

Download the GDI Mobile App

- 24/7 access to your accounts on your mobile device
- Check balances, file claims, and view account activity
- Use the app to take pictures of receipts and upload to accompany claims



Frequently Asked Questions

When can I enroll in MERA or Dependent Care?

You must enroll each year during Open Enrollment in order to participate in the MERA or Dependent Care FSAs for the following year. The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. New employees are eligible to participate upon hire.

How do I submit claims for reimbursement?

The Wesleyan MERA (Medical Reimbursement Account) and Dependent Care Flexible Spending Accounts are administered by Group Dynamic, Inc. When you enroll, a Welcome Packet will be mailed to your home. You will be issued a debit card to charge your expenses. The MERA debit card will be loaded at the beginning of the plan year with your annual election. Funds for the Dependent Care Flexible Spending Account will be loaded to your debit card after each of your paycheck contributions.

Once you incur an expense, if you don't charge it to your card, you can request reimbursement from your account. Keep your receipts and Explanations of Benefits (EOBs) in the event the vendor or the IRS requests additional information on your transactions.

I used my debit card to pay for a procedure. Why is GDI asking me for a receipt?

The IRS requires substantiation for all claims. GDI has set up a copay matching program to help limit the receipts needed. However, when a purchase does not match a set copay amount, a receipt may be needed to verify the expense as qualifying under the MERA plan. **If you do not supply a receipt when asked, your card may be suspended until you resolve the claim to ensure compliance with IRS claims substantiation requirements. This is true even if the claim in question was incurred in the prior plan year.**

What happens if I use the account for non-eligible expenses?

If you file a request for reimbursement of a non-eligible expense, the request will be denied by GDI. If the expense is deemed ineligible after the expense is already paid, you will be required to reimburse your account for that transaction. If you fail to reimburse the account, you may be required to pay income taxes.

What happens if I do not use all of the money in my account?

The IRS regulates Flexible Spending Accounts under IRC 125. According to the IRS guidelines, funds that are not claimed during the plan year are forfeited to the plan. This is called the "use it or lose it" clause. The unused funds are retained by the plan sponsor, your employer, and can be used to offset administrative costs of the plan.

Wesleyan allows employees to use their unused 2023 account balances to pay for qualified expenses incurred by March 15, 2024 provided they are submitted for reimbursement by April 15, 2024.

*Please note - For your remaining FSA balances from the 2022 plan year, you may use your unused 2022 FSA balances to pay for qualified expenses incurred through March 15, 2023. These claims must be submitted for reimbursement by April 15, 2023.

May I use my MERA for my spouse's deductible and copay expenses?

Yes. All eligible out-of-pocket expenses incurred by you and your tax-qualified dependents can be reimbursed by your MERA even if not enrolled under Wesleyan's medical plan. Please note, however, this may affect their eligibility for an HSA with their employer.

DENTAL BENEFITS

Dental Questions?

View covered services, claim status or your account balance, find a dentist, update your information, and much more at www.deltadentalnj.com.

Wesleyan offers two dental plan options through Delta Dental of New Jersey. Although both plans allow you to choose any dental provider, when you use an in-network dentist, you will generally pay less for treatments because your share of the cost will be based on negotiated discount fees. **With out-of-network dentists, the plan will pay the same percentage, but the reimbursement will be based on out-of-network rates. You may be billed for the difference.**

	Core Plan		Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Employee only	$50		$50	
Family coverage	$150		$150	
Is the deductible waived for preventive services?	Yes		Yes	
Annual plan maximum (per individual)	$1,200*		$2,000*	
Diagnostic and Preventive*				
Oral exams, x-rays, cleanings, fluoride (for children), space maintainers	100%		100%	
Basic				
Oral surgery, fillings, endodontic treatment, periodontic treatment, and sealants	80%		80%	
Major				
Crowns, jackets, implants, dentures, bridge implants, repairs of dentures, and crowns	50%		60%	
Orthodontia				
Adults and dependent children	50%		50%	
Lifetime orthodontia plan maximum (per individual)	$1,500		$2,000	

*Diagnostic and preventive services do not apply towards the annual maximum.

For more information on your dental benefits please visit wesleyan.edu/hr/health-benefits/dental.html.

Delta Dental Carryover Max

This benefit features allows you to carry over a portion of your unused annual maximum in one year to increase benefits for the following year and beyond!

TO QUALIFY FOR CARRYOVER MAX BENEFITS, YOU MUST MEET THE FOLLOWING CRITERIA:

- You must enroll on or before January 1st of the Carryover Max benefit year. Members enrolling after January 1st are not eligible to accrue carryover benefits until the start of the next plan year.
- You cannot use more than 50% of the annual maximum during the plan year.
- You must see a dentist during the plan year for an exam or cleaning and submit a claim for those services. If a claim for an exam or cleaning is not received, any accumulated Carryover Max benefit will be lost.

If you meet these criteria, you can accumulate 25% of the unused annual maximum. You can continue to accumulate benefits up to twice the annual plan maximum (annual benefits plus accumulated benefits), therefore the accumulated amount will never exceed the annual plan maximum amount.

Claims will always use the plan's annual maximum first. The accumulated benefit is applied when the standard annual maximum is exhausted.

VISION BENEFITS

Eye Exams Through Cigna

Annual eye exams are covered under the Wesleyan medical plans as a wellness benefit.

- Eye exams are covered at no cost for in-network eye doctors (use Cigna Vision Directory to verify providers).
  - Cigna Vision Directory
  - Out-of-network eye exams will be reimbursed up to $75.
- There is no Cigna reimbursement for glasses or contacts; however the voluntary EyeMed Vision plan is available (see below).
- Premiums for this benefit are covered under your medical plan.

EyeMed Voluntary Vision Coverage

EyeMed's vision care benefits include coverage for standard lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the EyeMed network. When you use an out-of-network provider, you will have to pay more for vision services.

Locating an EyeMed provider

In-network providers include private practitioners as well as selected chains, including LensCrafters, Target, Sears, and Pearle Vision. To locate a provider, visit www.EyeMedvisioncare.com and choose the Select network.

	In-Network Member Cost	Out-of-Network Reimbursement
Frames	$150 allowance, 20% off balance over $150	up to $75
Standard Lenses (once per frequency period)		
Single Vision	$20	up to $11
Bifocal	$20	up to $25
Trifocal	$20	up to $49
Premium Lenses		
Standard Progressive	$85	up to $25
Premium Progressive	80% of retail price less $35 allowance	up to $25
Contact Lenses ($20 copay waived)		
Elective	$150 allowance, 15% off balance over $150	up to $120

Frequency:

- Frames — Once every 24 months
- Standard Plastic Lenses or Contact Lenses — Once every 12 months

EyeMed Discount Programs

If you are covered under the EyeMed vision plan, you have access to the following discount programs:

Members - Only Special Offers:

Register on **eyemed.com** or download the EyeMed Members App to access the latest list of special offers for vision-related products and services. New offers are added often, so check before you go!

- Discounts on frames and lenses
- Exclusive offers from network providers and retailers
- Free shipping from online providers
- Savings on contacts
- Free vision products, like lens cleaner kits and more, all from EyeMed network providers
- Independent Provider Network, LensCrafters, Pearle Vision, Target Optical:
  - 20% off non-prescription sunglasses
  - No coupon or code required

*Redeemable at participating Sunglass Hut stores and online at sunglasshut.com. Excludes Cartier, Celine, Chanel, Costa, Dior, Maui Jim, Michael Kors, Ray-Ban x Disney Collection, Ray-Ban Jr., Oliver Peoples, Tiffany and Tom Ford. Not valid with any other coupons, discounts or promotional offers.

WELLNESS PROGRAM

The mission of the Wesleyan's Wellness Program is to establish a work environment that encourages faculty, staff, and their families to take responsibility for their physical and mental well-being through health awareness and healthy lifestyles. This program supports a comprehensive approach to decreasing the incidence, duration, and severity of preventable illnesses and disease by promoting educational opportunities, wellness activities, and self-improvement.

Start earning today!

Cardinal Fit Incentive Points Program

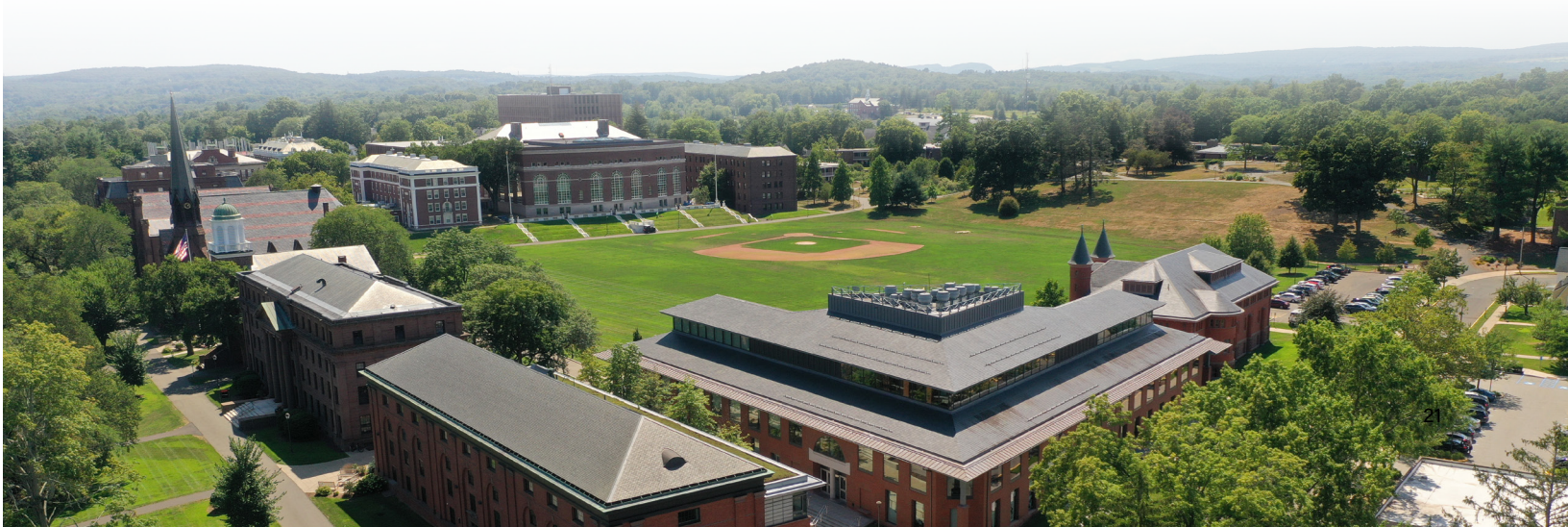
Wesleyan's Cardinal Fit Incentive Points Program rewards individuals dedicated to improving their health and well-being. You and your spouse or domestic partner can earn points by actively participating in health improvement programs and activities that can then be redeemed for cash payments. Benefit-eligible faculty, staff, spouses, and domestic partners are eligible to participate and earn points (up to $150 each on a semi-annual basis).

Wellness points are entered through the Wellness Points Tool which is available under "My Information" in your WesPortal account.

Note: To add or change a spouse or partner, please click the Spouse/Partner link at the top of the screen.

Wesleyan Adult Fitness Classes

Wesleyan offers free fitness classes for all faculty and staff. Visit Adult Fitness Class Offerings to learn more.



LIFE INSURANCE

The following options are available to eligible employees. Please keep in mind these benefits are reduced starting at age 65.

Basic Life Insurance (University Provided)

Wesleyan provides Basic Life insurance at no cost to you. The plan covers you at one times (1x) your salary (capped at $50,000). This coverage is guaranteed issue and provided for all benefit-eligible employees.

Supplemental Life

You may increase your life coverage by purchasing supplemental life coverage for yourself and your dependents.

If you elect supplemental life when initially eligible, you will receive up to the guaranteed issue amount without Evidence of Insurability (EOI). You will be required to complete EOI for any election over the guaranteed issue amount.

If you decide to increase coverage or make any changes after your initial eligibility, you will be required to provide EOI.

Guaranteed Issue

Guaranteed Issue is the highest amount of coverage that can be issued to you without Evidence of Insurability (EOI). If you do not enroll when you are a new employee, you will need to complete EOI for any amount of coverage for which you apply.

Newly hired employees are offered coverage with a guaranteed issue amount (no EOI needed) as follows:

- Employee - Guaranteed issue up to $200,000
- Spouse/Partner - Guaranteed issue up to $30,000
- Enrollment must be within the first 31 days after hire

Naming a Beneficiary

A beneficiary must be designated for employee basic and supplemental life insurance. The faculty or staff member is assumed to be the beneficiary for spouse/qualified domestic partner and dependent children life insurance. If you wish to change your beneficiary, you may do so at any time. Please complete the beneficiary form and return it to benefits@wesleyan.edu.

Group Term Life	100% Paid by the Employer
Employee	1x annual salary up to $50,000 Minimum coverage level: $10,000

Age reduction schedule:
Ages 65-69: Coverage = 35% of original benefit
Age 70+: Coverage = 12.25% of original benefit before age 65 reduction

Supplemental Life	100% Paid by the Employee	Guaranteed Issue
Employee	1-5x base annual earnings up to $750,000	$200,000
Spouse	$10,000 increments up to $100,000 not to exceed 50% of employee amount	$30,000
Child	$5,000 $1,000 (if child < 6 months of age)	$5,000 $1,000

Age reduction schedule:
Ages 65-69: Coverage = 35% of original benefit
Age 70+: Coverage = 12.25% of original benefit before age 65 reduction

The amount of coverage for a dependent cannot be more than 50% of your life insurance amount. Rates for employee and spouse supplemental life are based on age and smoker/non-smoker status. Spouse rates are based on the spouse's age.

For each $1,000 of optional life insurance coverage, the monthly rates are:

Age*	Non-Smoker Monthly Rates (per $1,000)	Smoker Monthly Rates (per $1,000)
0-24	$0.04	$0.05
25-29	$0.04	$0.05
30-34	$0.05	$0.06
35-39	$0.06	$0.07
40-44	$0.07	$0.09
45-49	$0.10	$0.15
50-54	$0.16	$0.23
55-59	$0.26	$0.38
60-64	$0.45	$0.65
65-69	$0.63	$0.92
> 69	$0.90	$1.30

Rates will increase on January 1st after age increases to the next bracket.
* Rates for optional spouse life are based on the spouse's age.

Evidence Of Insurability (EOI): Insurance companies are able to request that employees and dependents provide medical information (Evidence of Insurability) when application for Supplemental Life occurs after 31 days of your initial benefit eligibility as a new hire and/or when the amount applied for exceeds specific maximums. When EOI applies, you and/or your dependents will need to complete a "Statement of Health" and submit it for review and approval.

Portability and Conversion: Portability and conversion are available if your eligibility or employment with Wesleyan ends, portability allows you to continue your term life coverage while the conversion option allows you to convert your term life policy into an individual whole life policy.

DISABILITY BENEFITS

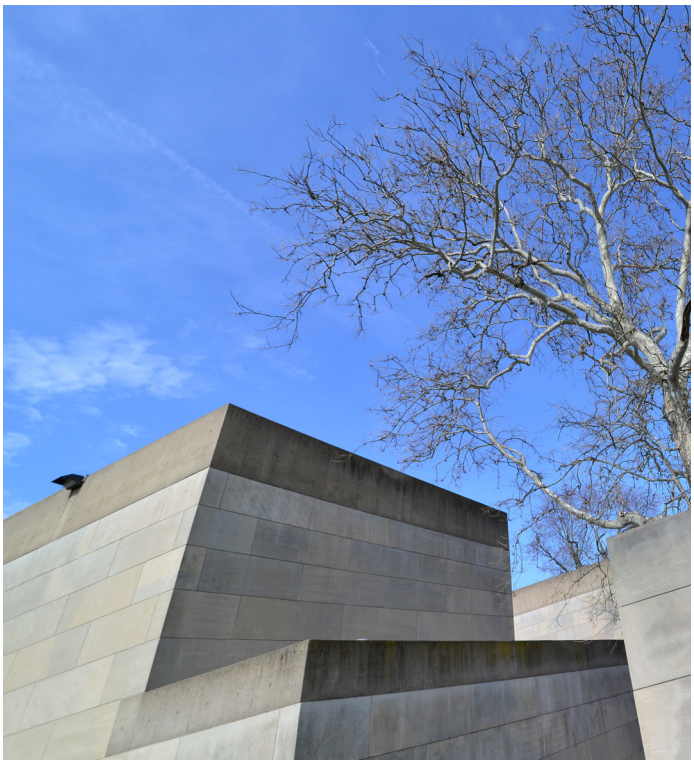
Short-Term Disability (STD)

Wesleyan provides short-term disability (STD) insurance to all benefit-eligible employees at no cost. STD insurance is designed to help you meet your financial needs if you become unable to work due to a non-work related illness or injury. The length of short-term disability will be determined by Wesleyan's STD insurance provider (Unum) but can be no longer than six months. Please refer to Wesleyan's Staff Handbook for plan details.

Long-Term Disability (LTD)

Wesleyan provides long-term disability (LTD) insurance through Unum to all benefit-eligible employees at no cost. If your disability extends beyond the short-term disability period, long-term disability benefits are available.

	Benefit Begins	Maximum Benefit Duration	Benefit Amount	Maximum Monthly Benefit
Long Term Disability	181st day of disability	■ Disabled prior to age 62 – up to Social Security Normal Retirement Age; ■ Disabled age 62+ - based on your age at the time of disability	60% monthly earnings	$11,500



Connecticut Paid Family and Medical Leave (CT PL)

The CT PL provides paid family and medical leave to eligible employees. The State's benefit will combine with Wesleyan's short-term disability or parental leave benefit to provide our current level of coverage between the two plans. Please visit the Wesleyan Human Resources leave site to review benefit coverage details.

Employees will apply for the State benefits through the State's selected leave administrator AFLAC. Please visit the State's CT PL site to review details of the benefit and how to file a claim.

Please visit the Wesleyan Human Resources leave site for more detailed information.

TRAVEL ASSISTANCE

Personal Travel Assistance (Employer-Paid)

Whenever you travel 100 miles or more from home for personal reasons – to another country or just another city – for less than 90 days, be sure to pack your worldwide travel assistance phone number! Travel assistance services, provided through Assist America, can help you locate hospitals, embassies, and other "unexpected" travel destinations. Just one phone call connects you and your family to medical and other important services 24 hours a day, 365 days a year.

Use your travel assistance phone number to access:

- Hospital admission assistance
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Download the Assist America Mobile App using reference number 01-AA-UN-762490. You can use the app to:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-trip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy

Expatriate/Extended Travel Program (Employee-Paid)

If you are traveling more than 100 miles from home for more than 90 days for personal reasons, you can purchase extended coverage through the Expatriate/Extended Program. This coverage complies with J-1 Visa Requirements.

Requirements:

1. You must be eligible for Assist America's Employer-Paid Travel Assistance Program.
2. The Expatriate/Extended Program must be activated before you leave on your extended trip.
3. Your spouse and children must be covered under the Wesleyan medical plan to be eligible dependents.

The Expatriate/Extended Program is available for an annual fee of $80 per individual or $120 per family. This program period coincides with the effective dates of your insurance policy, regardless of when you enroll. The program is not prorated.

To register, complete the enrollment form on the Assist America website at www.assistamerica.com/Expatriate-Application and enter your Assist America reference number (01-AA-UN-762490) to activate the program. The annual fee must be paid in full at time of enrollment.

If you have questions regarding the Expatriate/Extended program, please call 1-800-872-1414.

Wesleyan also provides business travel assistance, link here for more information.

RETIREMENT PLAN

The Wesleyan University Retirement Plan allows all non-student employees to contribute towards their retirement and provides employer contributions and match to eligible employees.

Employer Contributions

Allows eligible employees to receive contributions made by Wesleyan. The University will contribute 7% of your annual salary up to $80,500, and 10% for earnings over $80,500.

Employee Contributions and Match

Allows eligible employees to set aside 1% to 85% of their annual earnings to the maximum IRS plan limits towards retirement. You have the option to set aside money on a pre-tax or after-tax (Roth) basis. For the employer matching program, Wesleyan will make an additional contribution to your retirement plan (up to 3%) if you contribute to a pre-tax or Roth after-tax account. For every $1.00 that you contribute up to 6% of your salary, Wesleyan will contribute $0.50. If you are contributing less than 6%, you may want to consider increasing your contribution so that you can maximize the match. If you do not contribute, you may want to consider enrolling so that you can receive the additional Wesleyan match.

Please Note: Wesleyan only provides a match in the pay periods in which you make a contribution. However, a true-up calculation will be done as soon as administratively feasible after the end of the plan year. The true-up provision will ensure that employees who contribute at least 6% of their eligible compensation during a plan year (7/1 to 6/30) will receive the full 3% Wesleyan-provided match, up to the IRS compensation limits, even if the participant doesn't contribute every pay period. Those employees who become newly eligible must begin contributing before compensation will be included in the true-up calculation.

Plan documents may be accessed by visiting the Human Resources website.

When Can I Change My Contribution Percentage?

You can change your pre-tax or Roth contribution percentage at any time during the year. Pre-tax and Roth deductions will automatically stop once you have reached the annual limit allowed by the IRS. Visit the Retirement@Work link on WesPortal, under My Information to enroll in the plan, select your provider or change your contributions.

2023 Contribution Limits

The maximum annual employee contribution to pre-tax or Roth for 2023 is $22,500. If you are age 50 and above, the annual catch up contribution is $7,500.

457(b) Plan

For eligible employees, contributions to the 457(b) plan are based on a dollar amount per calendar year, percentages are not allowed. The maximum contribution to a 457(b) plan in 2023 is $22,500. Visit the Retirement@Work link on WesPortal, under My Information to enroll in the plan or change your contributions.

Note: Employees covered under collective bargaining agreements should email benefits@wesleyan.edu to confirm eligibility and plan rules.

EMPLOYEE ASSISTANCE PROGRAM

What is an EAP?

As an employee at Wesleyan, you and your household members have access to a wealth of support and services from our Employee Assistance Program (EAP). Provided by BHS, the EAP gives confidential, in-the-moment support to help with personal or professional concerns that may interfere with work or family responsibilities. The cost of EAP services are paid entirely by Wesleyan.*

What Happens When You Call the EAP?

A Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.*

MyBHS Portal

The mobile-friendly MyBHS customer portal provides access to more than 500,000 tools and resources on a variety of well-being and skill-building topics.

Features:

- Program Information
- Access to Services
- Announcements
- Assessments
- Café Series Webinars
- Training Center
- Calculators
- Legal Forms
- News & Tips

Access to the MyBHS Portal online or via the app.

portal.BHSonline.com

ID: **WESLEYAN**

Download App:

Or click below:

App Store

Google Play

Common Reasons to Call Your EAP

Relationships

- Supervisor / Coworker
- Customers
- Friends
- Spouse / Kids

Life Events

- Birth / Death
- Health / Illness
- Marriage / Divorce
- Promotion / Retirement

Risks

- Burnout / Anger
- Depression / Anxiety
- Suicidal Thoughts
- Substance Abuse

Challenges

- Daily responsibilities
- Financial / Legal
- Parenting
- Stress / Conflict

Program Features

Work Life Support Provided by the EAP

- Childcare and Eldercare Resources and Referrals
- Legal Assistance - Free 30-minute consultation and 25% discount on future services
- Financial Services such as counseling, information, and education

Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.

Information about your problem cannot be released without your written permission.

Available 24/7

Services are available 24-hours a day, 7-days a week via a toll-free number.

Supervisory Support - For help with challenging situations, skill-building, and problem-solving, Wesleyan supervisors can connect to a BHS Performance Consultant by calling 866-594-7292.

*If you require a referral for long-term treatment, costs may be incurred. These are often covered by your health insurance plan.

CONTACTS

Medical Plan

Cigna
Member services: 1-800-244-6224
Technical support: 800-853-2713
General website: www.cigna.com
Enrolled in medical: myCigna.com

Telehealth

MDLIVE: Initiate a consultation through myCigna.com
MDLIVE: 888-726-3171 or visit mdliveforcigna.com

Prescription Services

Mail-order pharmacy: 800-835-3784
Website: myCigna.com

Wellness Program

www.wesleyan.edu/hr/health-benefits/wellness.html

Health Savings Account

Cigna
Customer service: 1-800-997-1654
Website: myCigna.com

Dental

Delta Dental
Customer service: 1-800-452-9310
Website: www.deltadentalct.com

Vision

EyeMed
Website: www.eyemed.com
Customer Service: 866-939-3633

Flexible Spending Accounts - MERA and Dependent Care

Group Dynamic, Inc. (GDI)
Customer service: 800-626-3539, Monday through Friday 8:00 AM - 5:00 PM ET.
Website: www.gdynamic.com/portal
Click on participants under the login menu at the top of the screen. If you are a new user, follow the prompts to create your username and password.

Employee Assistance Program

UNUM
Website: www.unum.com/lifebalance
Toll-free 24/7 access: 1-800-854-1446 (multi-lingual)

Life Insurance

UNUM
Customer service: 1-866-679-3054
Monday - Friday 8:00 AM - 8:00 PM ET

Short and Long-Term Disability

UNUM
Customer service: 1-866-679-3054 Monday - Friday 8:00 AM - 8:00 PM ET
Website: www.unum.com

Worldwide Personal Travel Assistance

UNUM (Assist America)
Website: www.assistamerica.com
Customer service:
Within the U.S.: 1-800-872-1414
Outside the U.S.: +609-986-1234
Email: medservices@assistamerica.com

Expatriate/Extended Program:
Website: www.assistamerica.com/Expatriate-Application
Customer Service: 1-800-872-1414

Worldwide Business Travel Assistance

Customer service: 1-215-942-8226
Website: www.internationalsos.com

Retirement

TIAA
Customer service: 1-800-842-2776
Website: www.tiaa.org/wesleyanct

Fidelity
Customer service: 1-800-343-0860
Website: www.fidelity.com

Retirement@Work

Visit the Retirement@Work link on WesPortal, under My Information

844-567-9090

Contact the Wesleyan Human Resources team by emailing **benefits@wesleyan.edu** or by calling **860-685-2100**.

REQUIRED NOTICES

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Wesleyan University and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Wesleyan University has determined that the prescription drug coverage offered by the Wesleyan University Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Wesleyan University Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Wesleyan University Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Wesleyan University Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description, or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Wesleyan University prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact the person listed below for further information or call 860-685-2100. **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 Wesleyan University changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2023
Name of Entity/Sender:	Donna Brewer
Contact—Position/Office:	Director of Employee Benefits
Address:	237 High Street, 4th floor Middletown, CT 06459
Phone Number:	860-685-2100

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

WESLEYAN UNIVERSITY
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

WESLEYAN UNIVERSITY GROUP INSURANCE PROGRAM & SUMMARY PLAN DESCRIPTION*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Wesleyan University that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if

you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Wesleyan University) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired, or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice, please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Donna Brewer
Director of Employee Benefits
860-685-2100

Effective Date

The effective date of this notice is: January 1, 2023.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

WESLEYAN UNIVERSITY EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Donna Brewer
Director of Employee Benefits
860-685-2100

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 Wesleyan University 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;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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 period[1] 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 Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Donna Brewer
Director of Employee Benefits
237 High Street, 4th floor
Middletown, CT 06459
860-685-2100

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Wesleyan University Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The Wesleyan University Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Cigna HDHP / 1,500 Plan	**In-Network**	**Out-of-Network**
Individual Deductible	$1,500	$1,500
Family Deductible	$3,000	$3,000
Coinsurance	100%	80%
Cigna OAP / 500 Plan	**In-Network**	**Out-of-Network**
Individual Deductible	$500	$1,000
Family Deductible	$500	$1,000
Coinsurance	100%	70%
Cigna OAPIN / 500 Plan	**In-Network**	**Out-of-Network**
Individual Deductible	$500	Not Covered
Family Deductible	$1,000	Not Covered
Coinsurance	100%	Not Covered

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Donna Brewer
Director of Employee Benefits
860-685-2100

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Wesleyan University Wellness Program is a voluntary wellness program available to Benefit eligible faculty, staff, spouses, and domestic partners. 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 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Benefits Guide.

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 Donna Brewer at 860-685-2100 or benefits@wesleyan.edu.

The information from the Biometric Screening the Health Risk Assessment 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, such as education or coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Wesleyan University may use aggregate information it collects to design a program based on identified health risks in the workplace, the 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) 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 Donna Brewer at 860-685-2100 or benefits@wesleyan.edu.

IMPORTANT NOTICE FROM WESLEYAN 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 Wesleyan University and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Wesleyan University has determined that the prescription drug coverage offered by the Wesleyan University Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at (860) 685-2100

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Wesleyan University	06-0646959
5. Employer address	**6. Employer phone number**
237 High Street, 4th Floor	(860) 685-2100

7. City	8. State	9. ZIP code
Middletown	CT	06459

10. Who can we contact about employee health coverage at this job?
Human Resources

11. Phone number (if different from above)	12. Email address
(860) 685-2100	benefits@wesleyan.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

[x] All employees. Eligible employees are:

Faculty members, administrative staff, and librarians, who work at least half-time (0.5 FTE or more)
Secretarial and Clerical employees who work at least half-time (0.5 FTE or more)
Physical Plant employees who work at least half-time time (0.5 FTE or more)
Public Safety employees who work at least half-time (0.5 FTE or more)

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[x] We do offer coverage. Eligible dependents are:

Your spouse or domestic partner; your or your spouse or domestic partner's child who is under age 26, including a natural child, stepchild, a legally adopted child, or a child for whom you or your spouse or domestic partner are the legal guardian; or an unmarried child aged 26 or over who is or becomes disabled and dependent upon you.

[ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $Refer to Benefits Guide
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTICE OF EMPLOYEE RIGHTS UNDER THE CONNECTICUT FAMILY AND MEDICAL LEAVE ACT (CTFMLA) & CONNECTICUT PAID LEAVE ACT (CTPL)

CONNECTICUT DEPARTMENT OF LABOR AND CONNECTICUT PAID LEAVE AUTHORITY

LEAVE ENTITLEMENT AND ELIGIBILITY:

The CTFMLA provides eligible employees, after 3 consecutive months on the job, up to 12 weeks of unpaid, job-protected leave during a 12-month period for qualifying family or medical leave reasons. Employees are entitled to return to their same job at the end of leave. The CTPL provides income replacement benefits to eligible employees who are unable to work for the same leave reasons. These leave options may run at the same time.

Qualifying reasons for leave include:

- The birth of a child and care within the first year after birth;
- The placement of a child with employee for adoption or foster care and care for child within the first year after placement;
- To care for a family member with a serious health condition. Family includes spouse (the person to whom one is legally married), sibling, son or daughter, grandparent, grandchild or parent, or an individual related to the employee by blood or affinity;
- Because of the employee's own serious health condition;
- To serve as an organ or bone marrow donor;
- To address qualifying exigencies arising from a spouse, son, daughter or parent's active duty service in the armed forces; or
- To care or a spouse, son, daughter, parent or next of kin with a serious injury or illness incurred on active duty in the armed forces.

It also allows eligible employees to receive two extra weeks of leave (up to a total of 14 weeks) in connection with an incapacity that occurs during pregnancy. CTFMLA further allows eligible employees to take up to 26 weeks of leave in a single 12-month period to care for a covered servicemember with a serious injury or illness.

Employees may also take up to 12 days of leave to deal with the effects of family violence separate from leave time available under state or federal law. While this is not protected under CTFMLA, it is protected under the Connecticut Family Violence Leave Act and an employee can apply for CTPL in connection with these absences.

Leave does not have to be taken all at once. Employees may take leave intermittently (in separate blocks of time) or to reduce their work schedule.

CTFMLA leave is unpaid. However, an employer may require, or an employee may request to use their accrued, paid time off. An employee may choose to preserve up to 2 weeks of their accrued, paid time off. This accrued, paid time off is in addition to the income-replacement benefits available to employees under CTPL.

APPLYING FOR INCOME-REPLACEMENT BENEFITS UNDER CTPL

Wage replacement benefits under the CTPL may also be available for CTFMLA absences. More information about Connecticut's Paid Leave program and instructions for how to apply are available at https://ctpaidleave.org/.

Some employers have received approval from the CT Paid Leave Authority to provide CTPL benefits to their employees through an approved private plan instead of through the state's CTPL program. Employers that have approved private plans are required to notify their employees how to file claims for benefits through their private plan and who the employees can contact for answers to questions about their plan. CTPL benefits are available for up to 12 weeks in a 12-month period, with an additional two weeks available to an employee for incapacity or medical treatment during pregnancy. Benefits are limited to 12 days for leave to deal with the effects of family violence.

EMPLOYER NOTIFICATION FOR CTFMLA LEAVE

Employees should provide at least 30-days advance notice to their employer of the need to take CTFMLA leave if they can. If they are unable to because they do not know they need leave, the employee must provide notice as soon as they can. An employer may require a medical certification to support a request for leave.

WHAT IS PROHIBITED?

The CTFMLA prohibits employers from:

- Interfering with or denying any rights provided by the CTFMLA or CTPL. Examples include, but are not limited to, improperly refusing to grant CTFMLA leave or discouraging employees from using CTFMLA leave or applying for CTPL benefits.
- Disciplining, terminating, discriminating against, or retaliating against any individual for taking CTFMLA leave or applying for CTPL benefits, for opposing or complaining about any unlawful practice, or being involved in any proceeding related to the CTFMLA.

If you believe that your CTFMLA rights have been violated, you can either file a complaint directly in Superior Court or with the Connecticut Department of Labor.

To file a CTFMLA complaint with the Connecticut Department of Labor, complete and submit the appropriate CTFMLA complaint form found or the Department's website found at THE CONNECTICUT FAMILY & MEDICAL LEAVE ACT and CT PAID LEAVE APPEALS.

More information about the CTFMLA is available at THE CONNECTICUT FAMILY & MEDICAL LEAVE ACT and CT PAID LEAVE APPEALS and CTPL at https://ctpaidleave.org/.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

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

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

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.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

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
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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	SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

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

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

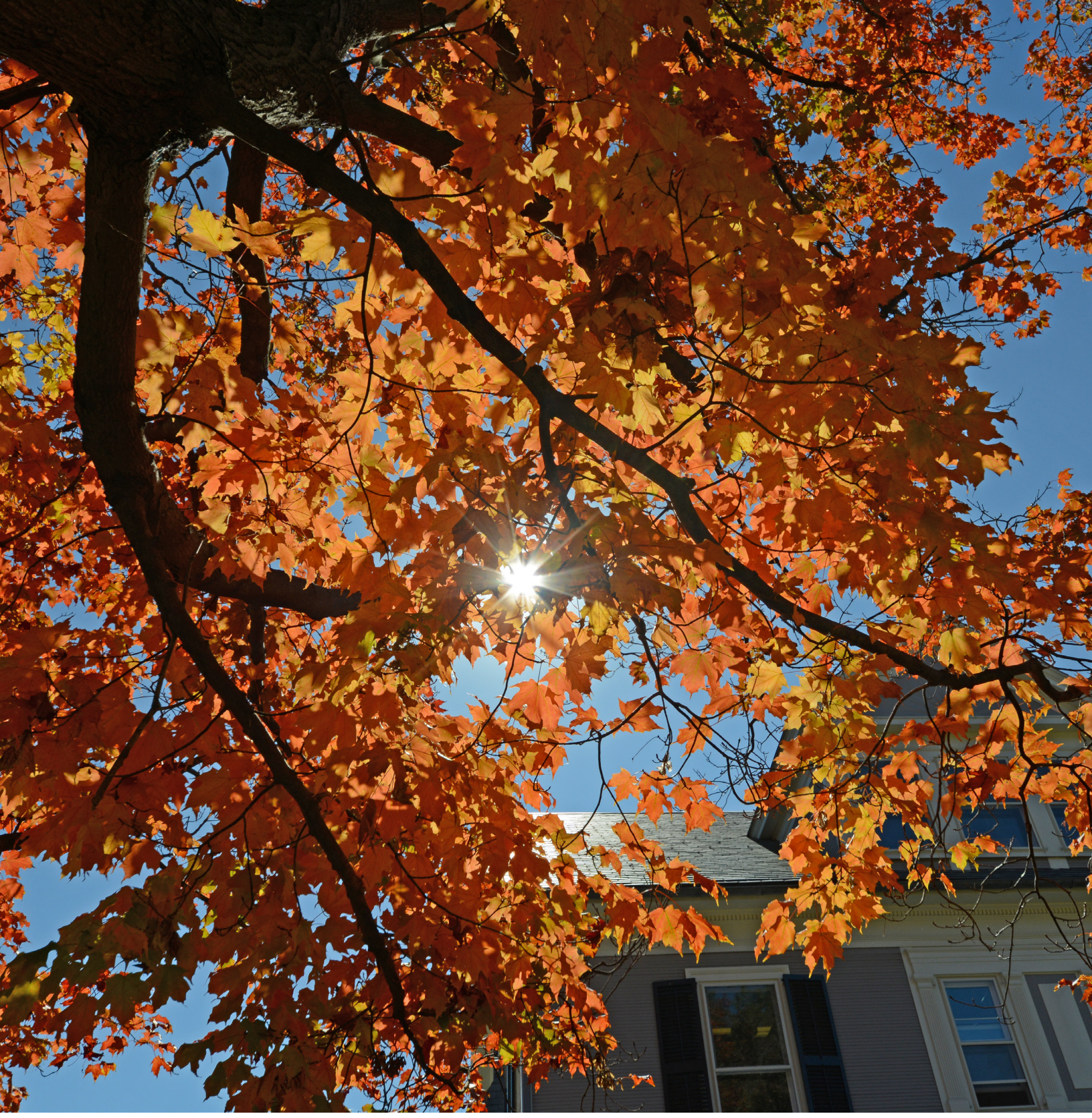
Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 1/31/2023)



Benefit Disclaimer

Benefit summaries are provided for the convenience of Wesleyan University employees. Employees are directed to read the relevant benefit plan documents. In the event of a conflict between the terms of a summary and the terms of the actual plan document, the terms of the plan document will control. Except where prohibited by collective bargaining or other agreement, Wesleyan University reserves the right to alter, modify or suspend any benefit at any time. While Wesleyan University selects its benefit providers after thoughtful review, it disclaims responsibility for the ultimate performance of such providers.