de paul group

2024 – 25

EMPLOYEE BENEFITS GUIDE

Welcome
to your benefits enrollment!

At The DePaul Group, we are committed to providing you and your eligible family members with an affordable benefits package that is comprehensive, while also being flexible enough to suit your needs.

This guide is designed to help you make informed decisions when selecting benefits for the plan year.

We encourage you to take some time to review this guide and take advantage of the various benefit programs and resources available to you and your family.

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Benefits Eligibility

Who is eligible to enroll in benefits?

Eligible employees

If you're a full-time employee at The DePaul Group, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week.

Eligible dependents

In addition, the following family members are eligible for medical, dental and vision coverage:

- **Lawful spouse:** Your lawful spouse is eligible for medical, prescription drug, vision, dental, and Basic Life coverage.
  - If adding a spouse for the first time, you are required to submit a marriage certificate.
- **Dependent children:**
  - Your child(ren) up to age 26 years: includes a biological or adopted son/daughter, stepson/stepdaughter.
  - Dependent children are eligible for medical, prescription drug, vision, dental, and Basic Life coverage through the end of the month they turn 26 years of age (unless the dependent is handicapped at which time they could remain as a dependent of the employee beyond age 26).

Enrollment and Making Plan Changes

How to enroll

Are you ready to enroll? It is important to weigh your options carefully. The decisions that you make during Open Enrollment will remain in place until next Open Enrollment, unless you experience a Qualifying Life Event.

The only form needed to be completed and signed when enrolling for the first time, changing plans, adding/dropping dependents or waiving coverage is **THE DEPAUL ENROLLMENT FORM**.

Key items to remember

1. New hire enrollment elections become effective the first of the month following the completion of 30 days of employment. If you do not enroll within this timeframe, you will not be able to enroll until our next Open Enrollment, unless you experience a Qualifying Life Event.
2. All elections you submit for enrollment will be final and **CANNOT BE CHANGED** during the plan year 8/1/2024 – 7/31/2025 unless you have a qualifying life event.
3. If you are **WAIVING** benefits this year, a completed DePaul Enrollment form needs to be submitted. You are required to complete the forms acknowledging you were offered benefits for this plan year.

Making Changes During the Plan Year — Qualifying Life Events

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

You must notify Human Resources within 31 days of experiencing a Qualifying Life Event.

Plan Options and Employee Contributions

For all benefit plans, you must enroll at the same tier level. Example: If you are enrolling in *single* coverage for Medical, you must also take *single* coverage for Dental and Vision.

- **Option 1:** Bundle Plan includes Medical/Prescription, Dental and Vision. If you enroll in the Medical/Prescription benefit options, Dental and Vision coverage are automatically included.
- **Option 2:** Enroll in Dental and Vision only, waive Medical.
- **Option 3:** Waive all coverage.

Consumer-Driven Health Plan #1*

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$44.64	$89.27
Employee + Spouse	$109.52	$219.03
Employee + Family	$125.30	$250.60
Employee + Child	$89.18	$178.36
Employee + Child(ren)	$89.18	$178.36

Point of Service Plan*

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$60.14	$120.27
Employee + Spouse	$147.61	$295.22
Employee + Family	$169.21	$338.42
Employee + Child	$119.83	$239.67
Employee + Child(ren)	$119.83	$239.67

Consumer-Driven Health Plan #2*

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$5.92	$11.84
Employee + Spouse	$14.28	$28.57
Employee + Family	$15.70	$31.40
Employee + Child	$12.45	$24.90
Employee + Child(ren)	$12.45	$24.90

Personal Choice PPO Plan*

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$105.63	$211.26
Employee + Spouse	$259.56	$519.11
Employee + Family	$297.98	$595.96
Employee + Child	$210.09	$420.18
Employee + Child(ren)	$210.09	$420.18

HMO Low Plan*

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$50.62	$101.25
Employee + Spouse	$124.23	$248.47
Employee + Family	$142.31	$284.63
Employee + Child	$101.13	$202.26
Employee + Child(ren)	$101.13	$202.26

Aetna Dental and Vision ONLY

BENEFIT	WEEKLY RATE	BI-WEEKLY RATE
Single	$2.10	
Employee + Spouse	$4.88	$9.74
Employee + Family	$4.88	$9.74
Employee + Child	$4.88	$9.74
Employee + Child(ren)	$4.88	$9.74

* Includes Aetna dental and vision coverage

About Your Medical Plan Options

The DePaul Group offers five medical plan options administered by Independence Blue Cross (IBX). Each medical plan includes prescription drug benefits through Future Scripts.

To locate participating providers, visit **www.ibx.com**. Also, download the IBX App to your smartphone to manage your health on the go!

For more information about your medical plans, see "Medical Plans At-a-Glance" on page 8.

Independence Blue Cross PPO — Consumer Driven Health Plans (CDHP1 and CDHP2)

A Consumer Driven Health Plan (CDHP) is an excellent option for an employee seeking to control his/her health care costs. A CDHP uses the same network as the traditional PPO and offers both in-network and out-of-network coverage for a premium significantly less than the traditional PPO.

- We offer two different Consumer Driven Health Plans with a High Deductible: CDHP1 & CDHP2.
- With these two plans only, you also have the option of pairing these with a Health Savings Account (HSA).

Keystone/AmeriHealth* HMO (Low) Health Maintenance Organization

This plan works with a specific group of doctors and hospitals within the network. A primary healthcare physician is selected, and you **must obtain referrals for care** that cannot be provided by the primary care physician (PCP).

A co-payment is charged at the time of visit. Please note that the choice of doctors and hospitals are limited to the network and out-of-network services will not be covered unless a trip to the emergency room is required.

Keystone/AmeriHealth* POS (Point of Service)

The Keystone/AmeriHealth POS in-network plan includes copayments. You must select a primary care physician (PCP), but you have the option to self-refer in-network or out-of-network.

Independence Blue Cross PPO — Personal Choice

You can receive care from any provider without a referral, in-network or out-of-network. Out-of-Network care will require a deductible and coinsurance may apply.

* Keystone HMO/POS service area covers Philadelphia and the surrounding counties. To verify if there are Primary Care Physicians in your area go to https://www.ibx.com/get-care/find-doctors-and-health-care-providers. Click on "Learn More" under doctors, hospitals, medical equipment, and specialty services. Enter your zip code under location and select Keystone HMO/POS/Direct POS under Plan.

* AmeriHealth is only for employees who are enrolled in a Blue Cross HMO or POS Plan and live in a county that is designated by Blue Cross to be a non-contiguous county. In New Jersey: Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Morris, Ocean, Passaic, Somerset, and Union. In Delaware: Kent, Sussex.

Additional IBX Plan Features

IBX's Partnership with WebMD

Searching for health information online can be frustrating. There is so much information to sort through, and it is difficult to know what is accurate. Thanks to Independence Blue Cross's partnership with WebMD, you can access reliable, personalized, up-to-date health information in one convenient location.

WebMD has decision-making tools to help you understand your health concerns and find the right treatment for them. They even offer tools to help you set, track, and attain your goals for better health.

WebMD is an independent company offering health information and wellness education to Independence Blue Cross members.

Healthy Lifestyles Solutions Programs

Independence Blue Cross, Keystone Health Plan East, and AmeriHealth offer incentives to help you make your health a top priority through their programs. For more information on these programs please refer to your provider packet.

- **Fitness:** Get up to $150 back when you join an eligible gym and workout regularly. You may also submit activity for virtual sessions through digital subscriptions or apps.
- **Weight Management:** Get up to $150 back when you participate in an approved weight management program.
- **Tobacco Cessation:** Get up to $150 back when you complete an approved program to help you quit using tobacco.

Medical Plans At-a-Glance

Administered by Independence Blue Cross (IBX)

	CDHP #1		CDHP #2		HMO Low	Point of Service (POS)		Personal Choice PPO	
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible (Individual/Family)	$1,600/$3,200	$5,000/$10,000	$3,000/$6,000	$5,000/$10,000	None	None	$1,250/$4,500	None	$500/$1,000
Out-of-Pocket Maximum (Individual/Family)	$5,600/$11,200	$10,000/$20,000	$5,600/$11,200	$10,000/$20,000	$5,000/$10,000	$3,000/$6,000	$10,000/$30,000	$1,500/$3,000	$3,000/$6,000
Primary Care Physician (PCP) Required?	No		No		Yes	Yes		No	
Preventive Care Services	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%	Plan pays 100%	Plan pays 50%; no deductible	Plan pays 100%	Plan pays Plan pays 70%*
PCP Office Visit	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$30 copay	$20 copay	Plan pays 50%*	$20 copay	Plan pays 70%*
Specialist Office Visit	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$50 copay	$40 copay	Plan pays 50%*	$30 copay	Plan pays 70%*
Routine Gyn Exam	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%	Plan pays 100%	Plan pays 50%; no deductible	Plan pays 100%	Plan pays Plan pays 70%*
Mammogram	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%; no deductible	Plan pays 50%; no deductible	Plan pays 100%	Plan pays 100%	Plan pays 50%; no deductible	Plan pays 100%	Plan pays Plan pays 70%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Routine Diagnostic: $50 copay MRI/MRA, CT/CTA Scan, Pet Scan: $100 copay	Routine Diagnostic: $50 copay MRI/MRA, CT/CTA Scan, Pet Scan: $100 copay	Plan pays 50%*	$30 copay	Plan pays 70%*
Emergency Room	Plan pays 100%*	Plan pays 100% after in-network deductible	Plan pays 100%*	Plan pays 50%*	$125 copay (waived if admitted)	$100 copay	$100 copay, no deductible	$40 copay (waived if admitted)	$40 copay (waived if admitted)
Urgent Care Center	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$87 copay	$70 copay	$70 copay	$28 copay	Plan pays 70%*
Inpatient Hospital	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$400 per day; $2,000 max/admission	$250 per day; $1,250 max/admission	Plan pays 50%*	$150 per day; $750 max/admission	Plan pays 70%*
Outpatient Surgery	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$50 copay	$40 copay	Plan pays 50%*	$30 copay	Plan pays 70%*
Emergency Ambulance	Plan pays 100%*	Plan pays 100% after in-network deductible	Plan pays 100%*	Plan pays 100% after in-network deductible	Plan pays 100%	Plan pays 100%	Plan pays 100%; no deductible	Plan pays 100%	Plan pays 100%; no deductible
Non-Emergency Ambulance	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Plan pays 100%	Plan pays 100%	Plan pays 100%; no deductible	Visits 1-30: $20 copay Visits > 30: $30 copay	Plan pays 70%*
Therapy Services	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$50 copay	$40 copay	Plan pays 50%*	$30 copay	Plan pays 70%*
Spinal Manipulations	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	$50 copay	$40 copay	Plan pays 50%*	$30 copay	Plan pays 70%*
Durable Medical Equipment	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Plan pays 50%	Plan pays 50%	Plan pays 50%*	Plan pays 100%	Plan pays 70%*
Chemo/Radiation/Dialysis	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Plan pays 100%	Plan pays 100%	Plan pays 50%*	Inpatient: $150 per day; $750 max/admission Outpatient: $30 copay	Plan pays 70%*
Mental Health	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Inpatient: $400 per day; $2,000 max/admission Outpatient: $50 copay	Inpatient: $250 per day; $1,250 max/admission Outpatient: $40 copay	Plan pays 50%*	Inpatient: $150 per day; $750 max/admission Outpatient: $30 copay	Plan pays 70%*
Substance Abuse Treatment	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Inpatient: $400 per day; $2,000 max/admission Outpatient: $50 copay	Inpatient: $250 per day; $1,250 max/admission Outpatient: $40 copay	Plan pays 50%*	Plan pays 100%	Plan pays 70%*
Injectable Medications	Plan pays 100%*	Plan pays 50%*	Plan pays 100%*	Plan pays 50%*	Standard: 100% Biotech/Specialty: $125 copay	Standard: 100% Biotech/Specialty: $100 copay	Plan pays 50%*	Plan pays 100%	Plan pays 70%*

* After deductible

Prescription Benefits

Administered by Independence Blue Cross/FutureScripts

If you enroll in one of the IBX medical plans you will automatically receive the corresponding prescription benefits, outlined below.

	CDHP #1 and #2	HMO, POS, and Personal Choice PPO Plans
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY) – IN-NETWORK COPAYS		
Generic	$5 copay after deductible	$20 copay
Preferred Brand	$20 copay after deductible	$40 copay
Non-Preferred Brand	$45 copay after deductible	$60 copay
MAIL ORDER (UP TO A 90-DAY SUPPLY) – IN-NETWORK COPAYS		
Generic	$10 copay after deductible	$40 copay
Preferred Brand	$40 copay after deductible	$80 copay
Non-Preferred Brand	$90 copay after deductible	$120 copay

About the Drug Formulary

Drugs that are on a formulary are grouped into tiers; your copayment is determined by the tier in which the medication is listed. Prescriptions with CDHP Plans are subject to the deductible. The deductible for some medications is waived.

- **Tier 1 (Generic)** has the lowest co-payment.
- **Tier 2 (Brand/Formulary)** has a higher co-payment than Tier 1 and usually includes medication the insurance carrier determines as formulary preferred.
- **Tier 3 (Non-Brand Formulary)** has the highest co-payment and usually includes non-preferred brand name medications. The insurance company may place a medication in Tier 3 because it is new or a specialty drug. The medication may be in Tier 3 because there is a similar drug on a lower Tier of the formulary that may provide the same benefit at a lower cost.

The Drug program is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness and value.

Medical experts have stated that generic drugs have the same active ingredients, are just as effective and provide a lower cost sharing for you and the plan.

Save On Your Medical/ Prescription Costs!

Future Scripts Mail Order Program

Using the mail order program through Future Scripts for your maintenance medications will **SAVE YOU MONEY**. You will receive up to a 90-day supply for two retail copays. In addition to the savings you'll receive, your prescriptions will be delivered right to your home.

If you are enrolled in the Personal Choice PPO plan, A 30-day supply of your maintenance medication purchased at a retail pharmacy costs:

- $20 for generic
- $40 for preferred brand name
- $60 for non-preferred brand name

How much can you save when you use Mail Order? Compare for yourself..

RETAIL PHARMACY	MAIL ORDER PHARMACY	ANNUAL SAVINGS
Preferred Brand-Name Copay **$40**	Preferred Brand-Name Copay **$80**	**$160**
Annual Cost ($40 per month x 12 fills) **$480**	Annual Cost ($80 per order x 4 fills per year) **$320**	

Urgent Care vs. Emergency Room

Urgent Care centers can be the perfect option for those that need medical attention for conditions that are not life threatening. You may opt out of an ER visit and instead visit Urgent Cares for the following:

- Minor fractures
- Back pain
- Minor headaches
- Nausea, vomiting, diarrhea
- Blood work
- Ear or sinus pain
- Cough or sore throat
- Lab services
- Animal bites
- Stitches
- Sprains and strains
- Mild asthma
- Allergies
- Minor allergic reactions
- Cold or flu symptoms

Emergency rooms will treat these problems also, but typically minor conditions such as these are not prioritized and those suffering from them can experience lengthy wait times.

90 percent of urgent care patients wait 30 minutes or less to see a provider, and 84 percent are in and out within an hour. Urgent care centers are typically more affordable than an ER visit, and there are convenient locations situated in places like shopping centers and commercial plazas.

Urgent Care is in-network with most major insurance providers, Medicare, Medicaid, worker's compensation and motor vehicle insurance.

Health Savings Account (HSA)

Administered by HealthEquity

If you are electing one of the Consumer Driven Health Plans (CDHP), you may be eligible to participate in a Health Savings Account (HSA). An HSA is a great way to save money by allowing you to set aside pre-tax dollars, via payroll deductions, to efficiently pay for qualified healthcare, dental and vision expenses.

The funds in your HSA never expire; you may utilize the money you accumulate in your account for future healthcare expenses, even if you change jobs or retire.

HSA Eligibility

In order to qualify for an HSA, you must be an adult who meets the following qualifications:

- You have coverage under an HSA-qualified, high deductible health plan (HDHP)
- You (or your spouse, if applicable) have no other health coverage (excluding other types of insurance, such as dental, vision, disability or long-term care coverage)
- Are not enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return

For more details on eligibility requirements, visit **www.irs.gov/publications/p969#en_US_2019_publink1000204025**.

HSA Contributions

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS and is dependent on whether you have individual or family coverage in one of the CDHP plans.

For 2024, the contribution limits are:

- $4,150 for individual coverage
- $8,300 for family coverage
- The annual catch-up contribution for age 55 and older is $1,000.

HSA Advantages

- There is no "use it or lose it" provision with an HSA. If you don't use the money in your account by the end of the year, don't worry! Unused funds will roll over year after year.
- HSA contributions are tax deductible, you can spend the money tax-free, and any growth is tax free.
- You can save and invest unused HSA money for future healthcare needs
- Your HSA is portable. When you retire or leave the company, your HSA funds go with you.

About the Health Savings Account

HSA-Qualified Healthcare Expenses

You can use the funds in your HSA to pay for qualified healthcare expenses such as:

- Doctor visits
- Dental care, including extractions & braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services
- Acupuncture
- Hearing aids and batteries
- Over-the-counter (OTC) medications
- Menstrual care products

For a full list of qualified medical expenses, visit **www.irs.gov/pub/irs-pdf/p502**.

Is an HSA right for me?

The decision is different for each individual. If you are generally healthy and/or have a reasonable idea of your annual health care expenses, then you could save a lot of money from the lower premiums and valuable tax-advantaged account with an HSA/HDHP plan. For example, even someone with a chronic condition could take advantage of an HSA/HDHP plan if he or she has a good idea of his or her annual expenses and then budgets enough money to cover cost of care.

However, if you are older, more prone to illness or unexpected medical conditions, or prefer certainty in medical costs over the possible risk of unexpected out-of-pocket expenses, you may want to stick with a traditional plan. You'll pay more in monthly premiums, but you will have a lower deductible and fixed copays.

Dental Benefits

Administered by Aetna

Eligible employees and their eligible family members may enroll in one of the Aetna dental plan options, which includes 100% coverage for preventive services such as routine dental exams, cleanings and X-rays.

Note: You can change between the DMO and DPPO plans during the plan year – rules vary by state as far as a maximum number of changes per year. In order for the plan change to be effective the 1st of the month, the change must be done before the 15th of the prior month.

	DMO Plan	DPPO Plan	
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible (Individual/Family)	None	$25/$150	$25/$150
Annual Dental Maximum (applies to Basic & Major services only)	None	$1,200	$1,200
Preventive & Diagnostic Services • Exams, Cleanings, Bitewing X-rays (each twice in a benefit period) • Full-mouth X-Rays (each twice in a calendar year)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Sealants (Permenant molars only)	Plan pays 100%	Not covered	Not covered
Basic Services • Amalgam (silver) fillings • Composite fillings (anterior teeth only) • Uncomplicated extractions • Gingivectomy	Plan pays 100%	Plan pays 80%	Plan pays 70%
Minor Restoration	Plan pays 100%	Plan pays 80%	Plan pays 70%
Major Services • Inlays, onlays, crowns • Full and partial dentures	Plan pays 60%	Plan pays 50%	Plan pays 40%
Orthodontics Covered Percent (children only; appliance must be placed prior to age 20)	Plan pays 60%	Plan pays 50%	Plan pays 50%
Orthodontics Lifetime Maximum (per patient)	None	$1,200	$1,200

About the DMO Plan

Under the DMO plan, members have their choice of skilled primary care dentists from the Aetna network. Select a primary care dentist who will then coordinate any needed referrals to a specialist. Covered services provided by Aetna dentists have preset copayments which are listed in your plan booklet. There are no maximums or deductibles.

About the DPPO Plan

The DPPO plan preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing an Aetna PPO dentist, who can complete claim forms for you and help advise you on questions.

Vision Benefits

Administered by VBA

Take care of your vision and overall health while saving on your eye care and eyewear needs. Vision insurance can help you maintain your vision as well as detect various health problems. Health conditions such as diabetes and high blood pressure can be detected early through a comprehensive eye exam.

Our vision plan is administered by Vision Benefits of America (VBA) and provides coverage for a range of vision care including exams, frames, lenses and contact lenses.

VBA Vision Plan

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Vision Exam	Plan pays 100%	$30 reimbursement
Frames	Plan pays 100%*	$40 reimbursement
Clear Standard Lenses (Pair)		
Single Vision	Plan pays 100%	$30 reimbursement
Bifocal		$40 reimbursement
Trifocal		$60 reimbursement
Lenticular		$80 reimbursement
Contact Lenses (includes the vision exam allowance)		
In lieu of glasses	$100 allowance	$100 reimbursement
Medically-necessary	UCR**	$250 reimbursement
Frequency		
Vision Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months, if needed	Once every 12 months, if needed
Frames	Once every 12 months***	Once every 12 months***

Note: A Preferred Discount for LASIK or PRK Vision Correction Procedures is available through TLC Laser Eye Centers

* Within the program's $40 wholesale allowance (approximately $90 retail)

** Usual, customary and reasonable as determined by VBA

*** If need or contact lenses (in lieu of all other benefits for benefit period and includes vision exam — once every 12 months)

Additional Charges Under the Plan

- Tinted lenses
- Photochromic lenses
- Polycarbonate/hi-index lenses
- Progressive/non-line multifocal lenses
- Lens coatings
- A frame that costs more than the plan allows

Not Covered Under the Plan

- Orthoptics or vision training
- Non-prescription lenses
- Two pairs of glasses (in lieu of bifocals)
- Medical or surgical treatment of the eyes
- Glasses and contacts during the same eligibility period

Basic Life/AD&D and Disability

Administered by New York Life

Basic Life and AD&D Insurance

Life insurance can help provide for your loved ones if something were to happen to you. The DePaul Group provides full-time employees with $50,000 in group life and accidental death and dismemberment (AD&D) insurance through New York Life.

The DePaul Group pays for the full cost of this benefit. For eligibility information, refer to page 3 of this guide.

BASIC LIFE AND AD&D BENEFITS	
Employee Life/AD&D Benefit	$50,000 (each life and AD&D)
Waiting Period	No waiting period
Dependent Life Benefit	Birth to 6 months: $100; 6 months to 19 years of age (or 26 years of age if a full-time student): $1,000 per child (No AD&D)

Short-Term Disability (STD)

Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work.

STD BENEFIT	
Benefit	60% of average weekly wages
Maximum Weekly Benefit	$1,000 per week
Elimination Period	7 days of continuous disability
Benefit Duration	12 weeks of continuous disability
Waiting Period	1st of the month following 30 days of continuous employment

Long-Term Disability (LTD)

Company-paid LTD provides you with income continuation in the event your illness or injury lasts beyond the later of 90 days or the date your insured STD payments end, if applicable. This helps ensure you have a continued income if you are unable to work due to a covered sickness or injury.

LTD BENEFIT	
Benefit	60% of pre-disability earnings
Maximum Monthly Benefit	$5,000 per month
Elimination Period	90 days or the date your insured STD payments end, if applicable
Benefit Duration	Social Security Normal Retirement Age (SSNRA)

Voluntary Life and AD&D Insurance

Administered by New York Life

While The DePaul Group offers basic life insurance, some employees may be interested in additional coverage based off their personal circumstances.

Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your spouse** or your dependent child(ren) as outlined in the chart below.

VOLUNTARY LIFE AND AD&D BENEFITS	
Employee Benefit	Increments of $10,000 up to 5 times salary or $500,000, whichever is less
Spouse Benefit	Increments of $5,000 to the lesser of $250,000 or 50% of employee's voluntary life amount
Dependent Child(ren) Benefit	Birth to 14 days: $500; Flat amount: $1,000; $2,000; $4,000; $5,000; or $10,000
Employee Guaranteed Issue*	$200,000
Spouse Guaranteed Issue*	$25,000

* Guaranteed issue amounts are only available to employees/spouses in their initial eligibility period.

** Spouse coverage ends at age 70

Evidence of Insurability (EOI)

EOI is required for elections made outside of the initial eligibility period for any amount elected.

Voluntary Life and AD&D Rates

AGE	EMPLOYEE/SPOUSE RATE PER $1,000
< 20	$0.066
20-24	$0.066
25-29	$0.066
30-34	$0.094
35-39	$0.134
40-44	$0.191
45-49	$0.305
50-54	$0.485
55-59	$0.746
60-64	$1.164
65-69	$2.021
70-74	$3.606
75-79	$3.606
80-84	$3.606
85-89	$3.606
90-94	$3.606
95-99	$3.606
CHILD RATE PER $1,000	
$0.295	

Employee Assistance Program (EAP)

Administered by New York Life

There are times when you cannot go it alone. With the New York Life EAP, you don't have to.

Sometimes we experience difficulties that cannot be resolved without the assistance of a trained professional. Unresolved issues with substance abuse, stress, anxiety, home life, and work life can affect or undermine our quality of living.

How the EAP Works

The EAP provides you and your family members assistance with behavioral healthcare services that can help begin the process of resolving emotional or substance abuse issues.

Emotional support for you and your family members is available at no additional cost. Services are available 24 hours a day, seven days a week. Includes work/life assistance, coaching, online articles, resources and videos.

How can the EAP help me?

The EAP can help you and your eligible family members through uncertain times, by acting as your advocate whenever you or your dependents need treatment of the following:

- Emotional Difficulties/Depression
- Family/Relationship Problems
- Stress/Anxiety Issues
- Grief and Loss Issues
- Alcohol/Drug Abuse or Addiction
- Anger/Rage Issues
- Eating Disorders
- Life Transition Problems
- Gambling Problems
- Other Behavioral Addictions

Remember: The encounter with the counselor through the EAP is completely confidential.

Health Advocacy Services

Administered by Health Advocate

Your Health Advocate services give you access to Personal Health Advocates who can support you in handling a wide range of healthcare-related and insurance issues to save you time, money, and worry.

Your conversations with Health Advocate will be conducted in a confidential manner, fully protecting your privacy.

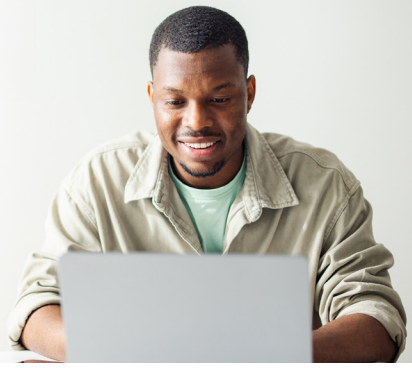
Under the Health Advocate Empowered Health program, you, your spouse and dependent children, your parents, and parents- in-law have access to a wide selection of benefits and services:

- Find doctors and arrange second opinions
- Resolve claims and billing issues
- Clarify health conditions
- Help you understand insurance
- Explain costs for services you may need
- Support for the whole family!

Getting Started

Simply call Health Advocate anytime, 24/7 at **866.695.8622**. You can also reach Health Advocate at **answers@HealthAdvocate.com** or by going to **www.HealthAdvocate.com/members**.

Benefits Carrier Contacts



COVERAGE TYPE	CARRIER NAME/CONTACT	PHONE NUMBER	WEBSITE
Medical	Independence Blue Cross	800.227.3114	www.ibx.com
Prescription Drug (Mail Order)	Future Scripts	888.678.7012	www.futurescripts.com
Dental	Aetna	877.238.6200	www.aetna.com
Vision	Vision Benefits of America (VBA)	800.432.4955	www.vbaplans.com
Life/Disability	New York Life	800.225.5695	www.newyorklife.com
EAP	New York Life	800.225.5695	www.newyorklife.com
Health Advocacy	Health Advocate	866.695.8622	www.healthadvocate.com/members

Have Questions or Need More Info?

The following DePaul Group contacts are also available to you:

- **DePaul Health Care:**
  - Contact Georgeann Polito at **609.472.0309** or **gpolito@depaulhealthcare.com**
- **Spring Mill Country Club/All other locations:**
  - Contact Barry Lee at **215.834.3200 x149** or **Barry.lee@depaulgroup.com**
- **Have questions about your benefits?**
  - Contact Health Advocate at **866.695.8622** (see page 19 for more info)

Glossary of Benefit Terms

Coinsurance

The amount or percentage that you pay for certain covered health care services under your plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment

A flat fee that you pay toward the cost of covered medical services.

Covered Expenses

Health care expenses that are covered under your health plan.

Deductible

A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent

Individuals who meet eligibility requirements under a health plan and are enrolled to receive benefits from the plan as a qualified dependent.

Health Savings Account (HSA)

An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

In-network

Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Out-of-network

Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and coinsurance.

Out-of-pocket Maximum (OOPM)

The highest out-of-pocket amount that you can be required to pay for covered services during a benefit period.

Premium

The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP)

A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance

The fee paid for covered services that is:

1. A similar amount to the fee charged from a health care provider to the majority of patients for the same procedure, and
2. The customary fee paid to providers with similar training and expertise in a similar geographic area, and
3. Reasonable in light of any unusual clinical circumstances.

Legal Notices

Special Enrollment Notice

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

Women's Health and Cancer Rights Act Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please speak with Human Resources.

Newborns' and Mothers' Health Protection Act Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Availability of Summary Health Information

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

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
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

Legal Notices

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
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
HIPP Phone: 1-800-766-9012

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gob/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

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: (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
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://mywvhipp.com/ and https://dhhr.wv.gov/bms/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

Legal Notices

To see if any other states have added a premium assistance program since January 31, 2024, 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

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

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the DePaul Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact Barry Lee at 610.834.3200 x149 or Barry.lee@depaulgroup.com. **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 [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Availability of Notice of Privacy Practices

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the [name of covered entity/group health plan] (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice, contact Barry Lee at 610.832.8000 ext 149.

The Genetic Information Nondiscrimination Act (GINA) Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Insurance Marketplace Notice

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024**, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

This section (see the chart below) 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 The DePaul Group	4. Employer Identification Number (EIN) 23-2573245	
5. Employer Address 409 Stenton Ave.	6. Employer Phone Number 610-832-8000	
7. City Flourtown	8. State PA	9. ZIP Code 19031
10. Who can we contact about employee health coverage at this job? Barry Lee		
11. Phone Number (if different from above) 610-832-8000 ext. 149	12. Email Address Barry.Lee@depaulgroup.com	

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This benefit guide provides selected highlights of the employee benefits program at DePaul Group. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at DePaul Group. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. DePaul Group reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.