

Benefits Guide

Oklahoma Baptist University

Comprehensive Guide to Employee Benefits

Table of Contents

Welcome to Open Enrollment.....1-3
Important information regarding the open enrollment period.

Trinity Captive Group Intro & Medical Benefits.....4-5
Plan summary and coverage rates

Pharmacy Benefits.....6-7

Understand your Rx benefits with mail-order services and Patient Navigator support.

Your ID Card & Finding A Network Provider.....8
Understand your ID card.

Emergency Room vs Urgent Care.....9-10
Learn to identify emergency symptoms.

Telemedicine.....11
24/7 Access to doctors for phone & video consultations.

Patient Navigator.....12-17
Patient Navigator Concierge service offering a variety of
free benefits including imaging, surgeries, a maternity program and mental health services.

FedLogic.....18
Learn more about free expert support for navigating federal and state benefits.

Online Access.....19-20
Access your plan online and through the mobile app.

Ancillary Benefits.....21-34

Cost Per Paycheck (Medical & Dental.....35

Contacts.....36
Contacts for questions about your benefits.

Required Notices.....37-54

WELCOME
OBU ENROLLMENT GUIDE

BENEFITS OFFERED

January 1, 2027- December 31, 2027

Welcome to your Oklahoma Baptist University (OBU) Benefits Guide. This Benefits Guide provides a broad overview of the benefits available to you and your family. The Guide includes benefit highlights for each plan and a quick reference page with provider and resource contact information. It is important that you understand your OBU benefits.

Helpful Tips to Consider Before You Enroll

- Do you plan to enroll an eligible dependent(s)? If so, make sure to have their Social Security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
- Have you recently been married/divorced or had a baby? If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
- Did any of your covered children reach their 26th birthday this year? If so, they may no longer be eligible for benefits unless they meet specific criteria.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, continuation of coverage may be available.

Eligibility Rules / Requirements

Employee Eligibility

You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective on the date you are hired.

Dependent Eligibility

The legal Spouse of an employee

- The definition of "legal spouse" is A person of the opposite biological sex to whom you are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

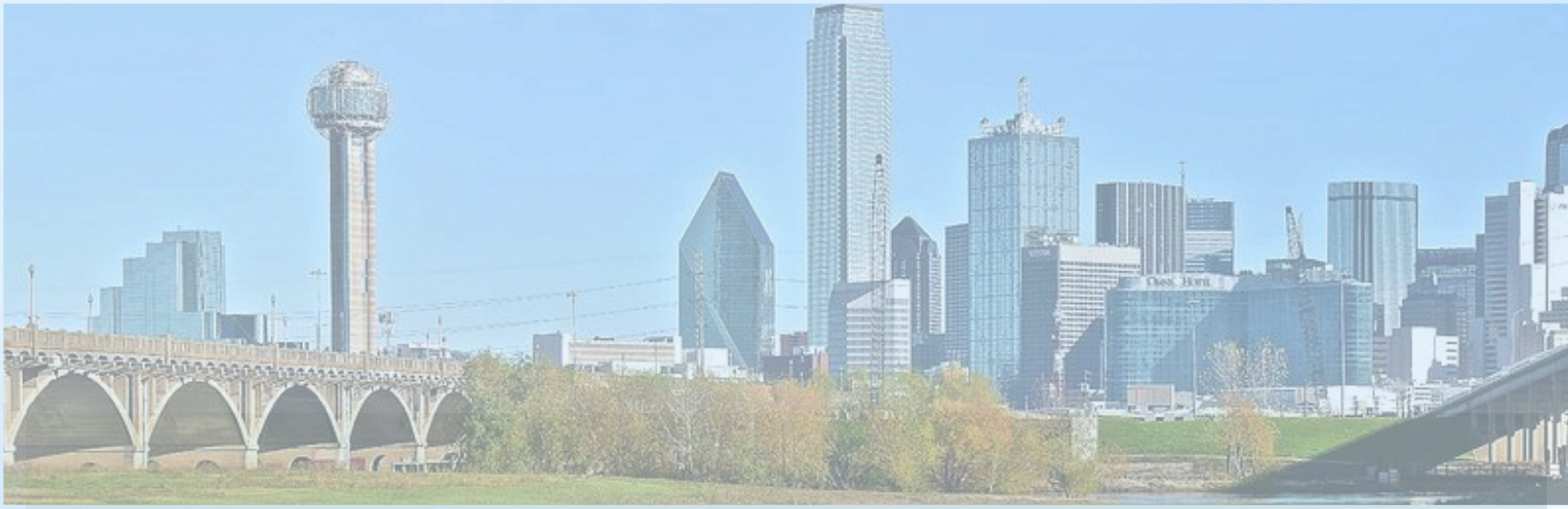
Children up to age 26

The definition of "your child" includes:

- Your and/or your Spouse's biological child
- Your and/or your Spouse's legally adopted child or a child placed in your home for adoption
- Your and/or your Spouse's stepchild or foster child
- Your and/or your Spouse's grandchild who is dependent on you for support and maintenance. (This definition must be met in order for any claims to be covered under the plan even during the first 31 days after the birth of the grandchild to your covered dependent.)
- A child for whom you or your Spouse must provide health care by court order or order of a state agency authorized to issue National Medical Support Notices under federal law

Incapacitated children of any age who meet the following requirements:

- You and/or your Spouse must be the legal guardian or managing conservator for the incapacitated child.
- The child must be developmentally disabled or physically handicapped and incapable of earning a living.
- The child must be incapacitated when his or her plan coverage would have ended because they turn 26.
- You must provide with proof of the child's disability or physical handicap at least 31 days before your child's regular coverage is scheduled to end. This is normally during the month before their 26th birthday.
- You must provide additional proof whenever asked to show that your child is still incapacitated. Coverage will remain in place through the approval process.
- A new employee may apply for coverage for an incapacitated child over age 26 during the initial eligibility as long as their prior coverage had approved the child as incapacitated.
- An existing employee may not add an incapacitated child to the coverage if they were not previously covered before reaching age 26.



Trinity Captive Group

Your employer has chosen to partner with Trinity Captive Group (TCG) with your best interest in mind. Our mission is simple: improve your healthcare experience and reduce the cost of care. We achieve this by partnering with innovative industry leaders to build a customized benefits package that passes real savings directly to you.

We believe that no one should forego care due to cost.

YOUR HEALTH COMES FIRST!

Preventive care and early detection are your most powerful tools for staying ahead of serious conditions and avoiding more invasive procedures down the road. Take charge and make the most of everything available to you through this program.

TCG $3,000 PPO PLAN

	PATIENT NAVIGATOR	In-Network	Out of Network
Deductible (Individual / Family)	**$0**	**$3,000 / $6,000**	$6,000 / $12,000
Out-of-Pocket Max. Individual / Family	**$0**	**$6,000 / $12,000**	$12,000 / $24,000
Coinsurance		20%	40%
Preventive Care		100% Covered (no charge)	Deductible + Coinsurance
Telemedicine		$0 Copay through Call-A-Doc	
Primary Doctor		$15 Copay	$25 Copay
Specialist		$25 Copay	$45 Copay
Labs		$0	Deductible + Coinsurance
X-Rays office visit/urgent care		$0	Deductible + Coinsurance
Advanced Imaging (CT/PET Scans & MRIs)	**FREE**	PET Scan: $750 Copay + Deductible/ Coinsurance CT Scan: $500 Copay + Deductible/ Coinsurance MRI: $250 Copay + Deductible/Coinsurance	
Urgent Care		$50 Copay	$250 Copay
Emergency Room		100% Covered and Deductible waived if true emergency Deductible + Coinsurance + $750 Penalty if Non-Emergency	
Inpatient & Outpatient Hospital Care		Deductible + Coinsurance	
Surgery Centers	**FREE**	Deductible + Coinsurance or contact Patient Navigator for NO COST options	
Pharmacy			
Generic / Preferred / Non-Preferred		**$0 / $15 / $30 Copay**	Not Covered
Specialty Rx	**FREE**	20% up to $1,000	Not Covered
Mail Order		2 Times Retail	Not Covered

Important Notice: This is a plan summary ONLY. Please refer to your plan's SBC or SPD for full details.

TCG $3,900 HSA PLAN

	PATIENT NAVIGATOR	In-Network	Out of Network
Deductible (Individual / Family)	**$0**	**$3,900 / $7,800**	$7,800 / $15,600
Out-of-Pocket Max. Individual / Family	**$0**	**$7,800 / $15,600**	$15,600 / $31,200
Coinsurance		20%	40%
Preventive Care		100% Covered (no charge)	Deductible + Coinsurance
Telemedicine		$0 Copay through Call-A-Doc	
Primary Doctor		Deductible + Coinsurance	Deductible + Coinsurance
Specialist		Deductible + Coinsurance	Deductible + Coinsurance
Labs		Deductible + Coinsurance	Deductible + Coinsurance
X-Rays office visit/urgent care		$0 after deductible	Deductible + Coinsurance
Advanced Imaging (CT/PET Scans & MRIs)	**FREE** after deductible	PET Scan: $750 Copay + Deductible/Coinsurance CT Scan: $500 Copay + Deductible/Coinsurance MRI: $250 Copay + Deductible/Coinsurance	
Urgent Care		Deductible + Coinsurance	$250 Copay + Deductible/ Coinsurance
Emergency Room		100% Covered after in-network deductible if true emergency Deductible + Coinsurance + $750 Penalty if Non-Emergency	
Inpatient & Outpatient Hospital Care		Deductible + Coinsurance	
Surgery Centers	**FREE** after deductible	Deductible + Coinsurance or $0 after IRS minimum in-network deductible through Patient Navigator	
Pharmacy (After Deductible)			
Generic / Preferred / Non-Preferred		Deductible + Coinsurance	Not Covered
Specialty Rx	**FREE** after deductible	Deductible + Coinsurance	Not Covered
Mail Order		2 Times Retail	Not Covered

Important Notice: This is a plan summary ONLY. Please refer to your plan's SBC or SPD for full details.

****The IRS minimum required in-network deductible of $3,500 must be met prior to utilizing the free services through Patient Navigator.**

Need Help Understanding Your Pharmacy Benefits?



Patient Navigator is here for you!

We make it easier to understand and manage your medication needs, including:

- ✔️ **Navigating high-cost medication alternatives**
- ✔️ **Specialty Medications**
- ✔️ **Infusion and chemotherapy coordination**

Specialty Rx:

Prescription drug benefits are coordinated by Verus, our Pharmacy Benefit Manager (PBM). Through VerusRx, you have access to a network of over 60,000 pharmacies — including a mail-order option to get your regular medications delivered directly to your door. If you take a specialty medication, contact Patient Navigator for personalized support and clinical guidance to secure your medication at the best available cost.

Call:
423-TCG-CARE
(423-824-2273)

Text:
423-824-2273

Email:
Free@TCNavigator.com

Mail Order Rx:

Easy online sign-up with the option of importing your medication history

An Amazon shopping experience with free shipping

VERUS Rx

24/7/365 access to a pharmacist

Clear pricing to help you save time and money

The ability to manage your medication and order history

Sign Up for Amazon Pharmacy Today!

Set up your Amazon Pharmacy account here:
www.amazon.com/homedelivery-meds

Choose Get Started. You'll need your member ID, RxBIN and RxPCN numbers which are listed on your member ID card.

For new prescriptions you'd like filled by Amazon Pharmacy, let your doctor know to send them to Amazon Pharmacy by:

E-SCRIBE: Amazon Pharmacy 001
FAX: 1-512-884-5981
MAIL: 4500 S Pleasant Valley Rd, Suite 201
Austin, TX 78744
PHONE: 855-206-3605, then press 1 (prescribers only)

*Mail Order Pharmacy does not dispense Schedule II controlled substance drugs.

Got A Script… Where Should I Take It…

Making informed choices helps support a healthier, more affordable plan for everyone.



Choose Cost-Effective Pharmacies

Even if your copay is the same, pharmacies charge the health plan different amounts.

- Stand-alone pharmacies often cost the plan more.
- **Grocery store** and **big-box pharmacies** (like **Sam's Club** or **Costco**) usually cost the plan less.

Choosing lower-cost pharmacies helps keep the plan affordable for everyone.

Taking a Specialty Medication? We're Here to Help.

Specialty medications can be complex—and costly. Always reach out to the **Patient Navigator** for:

- Personalized medication support
- Clinical guidance
- Help securing your medication at the best available cost

Patient Navigator Contact
Phone: **423-824-2273**
Email: **Free@TCNavigator.com**

Compare Prices With GoodRx

Some medicines may cost less when you use GoodRx instead of using your insurance card.

- Use GoodRx if it gives you a lower price.
- Prices can vary a lot by pharmacy, so checking helps you save money.

Using GoodRx can lower your out-of-pocket costs and help keep the health plan costs down.

Your Participation Matters

By making smart choices—like filling your prescriptions at a **grocery or big box store**, comparing prices, and asking for help when you need it—you can:

- Keep the benefit plan financially healthy
- Help keep future premiums and costs lower
- Make care more affordable for everyone

Small choices add up. Being an informed user of your prescription benefits is a great place to start.

NEED MORE INFORMATION ABOUT YOUR PRESCRIPTION BENEFITS?
CONTACT OUR TEAM FOR GUIDANCE.



Understanding Your ID Card

ASSURED BENEFITS ADMINISTRATORS

United Healthcare

HERE'S THE KEY INFORMATION YOU NEED TO KNOW ABOUT YOUR MEDICAL ID CARD:

- ·Your Member ID and Group Number are used at every provider visit
- Proactively advise the front desk team that you have a self-funded plan with the **UnitedHealthcare Choice Plus Network.**
- **Assured Benefits Administrators (ABA)** administers your claims | **Payor ID: 39026**
- Your pharmacy benefit information is also listed on the card.

Make sure to call Patient Navigator to verify if your specialty medication can go through the program at no cost instead.

YOUR GO-TO CONTACTS

Call Patient Navigator First - Trinity Care
Your personal concierge for free services and navigating your care.

Call or text: 423-TCG-CARE (423-824-2273)
Email: Free@TCNavigator.com

For Claims, Eligibility & Pre-Authorizations:
Assured Benefits Administrators (ABA)

Call: (888) 830-0179
Email: ASOEligibility@abadmin.com

FRONT

UnitedHealthcare | Shared Services

Member ID: 790040001111 Issuer: (80840) Group Number: 78800245

Group Name: Badeco
Member: John Doe
Medical Copay:
Doctor Visit / Specialist: $15 / Urgent Care: $50

Medical Coinsurance:
Individual In-Network: $1,000 deductible, then 80%
Individual OON: $2,000 deductible, then 60%
Out-of-Pocket Maximum:
Individual In-Network: $3,500 / OON: $4,500

Rx Copay Retail (30-day supply):
Generic $15 / Brand $35 / Non-Form $75
Specialty $250
Rx Copay Mail Order (90-day supply):
Generic $37 / Brand $87 / Non-Form $187

VERUS Rx
Rx BIN: 610014
Rx GRP: RXBHABR

UnitedHealthcare Choice Plus Network

PROVIDERS CALL 888-830-0179

UnitedHealthcare Shared Services
Provider Directory:
https://whyuhc.com/uhss

BACK

This card doesn't guarantee coverage. Printed: 08/28/2023

You, or your provider, must call 866-207-2260 prior to a hospital admission.
FAILURE TO CALL FOR PRIOR AUTHORIZATION MAY REDUCE BENEFITS.

Telemedicine - A
Patient Navigator – Trinity Care
423-TCG-CARE (423-824-2273)

For Members:	www.abadmin.com	866-231-5589
Rx Help Desk:	express-scripts.com	800-922-1557
Rx E-Fax:		800-334-8134
For Providers:	https://uhss.umr.com	888-830-0179
Clinical Intake:		866-207-2260
Medical Claims:	EDI # 39026, UHSS, PO Box 30783, Salt Lake City, UT 84130-0783	

VISIT UHC.COM/FIND-A-DOCTOR →CLICK "GUEST PROVIDER SEARCH"

TIP: ALWAYS CALL THE PROVIDER DIRECTLY TO CONFIRM THEY ARE IN-NETWORK BEFORE YOUR VISIT.



NEED IMMEDIATE CARE?

Trinity Captive Group wants to make sure you understand emergency symptoms to watch for. For a detailed list, visit **MedlinePlus** through the **National Library of Medicine** or **other credible online sources**.

Symptoms of a ***medical emergency*** include but are not limited to:

- Heart problems or chest pain
- Breathing issues, choking, coughing up or vomiting blood
- Heavy bleeding
- Broken bones or severe injuries
- Severe pain, sudden dizziness, mental confusion, or change in vision

Some symptoms that commonly cause people to visit the ER but could be easily treatable at an ***Urgent Care Facility*** include:

- Colds, sore throats, and flu symptoms
- Ear or sinus pain
- Rashes
- Cuts that don't need stitches
- Constipation
- Tolerable pain

Learn to recognize true emergency symptoms, listen to your body and act accordingly.

CHOOSING THE APPROPRIATE LEVEL OF CARE

Become an educated consumer and avoid surprise bills.



24/7 Telemedicine

If you are experiencing any minor illnesses or injuries, consider reaching out to Call-A-Doc.

You have access to board certified physicians **24/7** at **NO COST!**

Call: (844) 362-2447
Visit: www.247calladoc.com

Emergency Symptoms?

For emergency symptoms or life-threatening injuries, go to the nearest emergency room for care.

Using the ER for non-emergencies results in a $750 penalty and the claim will be subject to your deductible and coinsurance.

If you were seen for emergency symptoms but received a non-emergency diagnosis, you will not be penalized. Contact Patient Navigator immediately if you receive a bill.

Urgent Care Facilities

For minor illnesses or injuries needing in-person care, visit a participating Urgent Care facility near you.
Costs are typically lower than the ER and wait times are shorter.

Beware: some facilities look like urgent care facilities but are hospital-owned and bill accordingly. Always verify before you go to avoid surprise bills.

Contact Patient Navigator First

Interested in any of the FREE services through Patient Navigator?

Call or text: 423-TCG-CARE (423-824-2273)
Email: free@tcnavigator.com
7:00am-6:00pm CST

Patient Navigator services include:

- Surgeries
- High-tech Imaging
- Colonoscopies/Endoscopies
- Infusions
- Specialty Rx
- More...

24/7 CALL A DOC

TELEMEDICINE

ACCESS TO DOCTORS24/7!

CARE AT YOUR FINGERTIPS!

Don't wait for an appointment. Many conditions can be treated through a phone or virtual consultation. They can even order most prescription medications and send them to the pharmacy of your choice.

$0
ENTIRE HOUSEHOLD



COMMON CONDITIONS TREATED BY TELEHEALTH PHYSICIANS

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Constipation
- Diarrhea
- Ear Infection
- Fever
- Gout
- Headache
- Infections
- Insect Bites
- Injuries
- Joint Pain
- Rashes
- Sinus Infection
- Skin Inflammation
- Sore Throat
- Sunburn
- UTIs
- And more...

CONTACT US ANYTIME, ANYWHERE!

(844) 362-2447

WWW.247CALLADOC.COM

Patient Navigator



Members enrolled in one of our plans receive access to our concierge service, **Trinity Care - Patient Navigator**. You may be eligible to receive a variety of high-quality services for **FREE**!

423-TCG-CARE (423-824-2273)

free@tcnavigator.com

- **Free surgeries — plus a $1,000 incentive for eligible procedures**
- **Free imaging — MRIs, CT Scans, Ultrasounds & more**
- **Free Colonoscopies**
- **Free Physical Therapy**
- **Free Durable Medical Equipment**
- **Free Infusion Therapy**
- **Some Specialty Rx***
- **Free Mental Health Services**
- **Free Maternity Program - Diapers & Wipes For a Year as participation incentive!**

Important Note: For HSA-qualified plans, services must follow IRS guidelines. Please contact Patient Navigator to ensure eligibility.

CALL US FIRST (7AM–6PM CST MON-FRI)

423-TCG-CARE (423-824-2273)

All members enrolled in a medical plan receive access to our white-glove concierge service to help you navigate your care.

Patient Navigator Free Imaging

$0

FREE IMAGING

STEP 1

CALL

Patient Navigator **FIRST (7AM–6PM CST)** prior to obtaining imaging services. This is required for 100% coverage through the program.

STEP 2

CHOOSE

Home/Work
AM or PM
What part of the week

STEP 3

SCHEDULE

Patient Navigator will schedule the appointment for you!

STEP 4

ATTEND

No ID card or payment is needed at the time of your appointment.

STEP 5

DONE!

Your physician will receive all imaging and reports.

Services Available:

- MRIs (open & closed)
- CT Scans
- PET Scans
- Ultrasounds
- Bone Density (DXA)
- Nuclear Medicine
- Arthrogram
- Echocardiogram

Important Note:
For services to be covered at $0, you must contact Patient Navigator before services are rendered, follow the steps as required, and go to the approved provider.

For HSA-qualified plans, services must follow IRS guidelines. Please contact Patient Navigator to ensure eligibility



PATIENT NAVIGATOR SURGERIES

Through direct contracts with over 4,000 high-quality surgical centers nationwide, you have access to NO-COST eligible surgeries!

NO Deductible
NO Coinsurance
$1,000 Incentive
PAID Travel / Hotel
$100 Per Diem

- Orthopedic (knee, hip, shoulder)
- General Surgery (hernia, gallbladder)
- ENT (ear, nose, throat)
- Gynecological Procedures
- Cardiovascular
- Ophthalmology (eye procedures)

Call Patient Navigator to verify your surgery is covered under the program. A dedicated concierge representative will guide you through every step, from scheduling to aftercare.

Call Us First (7AM–6PM)
423-TCG-CARE
(423-824-2273)



For HSA-qualified plans, services must follow IRS guidelines. Please contact Patient Navigator to ensure eligibility.

FREE MATERNITY PROGRAM



Expecting a baby, or thinking about growing your family? This benefit is for you.
Enroll in our comprehensive maternity program for unlimited, on-demand access to maternal-fetal medicine OB/GYN specialists who can answer your questions, support your journey, and help manage high-risk pregnancies. You'll also have access to prenatal nurse navigators, lactation consultants, and behavioral health specialists throughout your pregnancy and up to a year port delivery.

After completing your 2-week post-delivery check-in, you'll qualify to receive **FREE DIAPERS AND WIPES FOR A YEAR** as a participation incentive!

You must enroll by your 14th week of pregnancy (unless otherwise approved).

To enroll, call patient navigator at 423-TCG-CARE (423-824-2273) and then visit the site below to complete your registration.

WWW.OUMAHEALTH.COM/PARTNERS/TRINITY

Trinity Captive Group | TPN.health

More Options. Better Outcomes.

Comprehensive Mental & Behavioral Health Support for You and Your Family

Patient Navigation connects you to the right care at the right time—at **no cost to you.*** From everyday support to specialized programs, we're here to help.



ONE CALL. REAL HELP. REAL SUPPORT.
Our Licensed Care Navigators are with you every step of the way.

A Full Range of Care. Personalized for you.

THERAPY & COUNSELING
Individual, group, and family therapy for a wide range of mental health needs.

PSYCHIATRY
Psychiatric evaluation, medication management, and ongoing support.

AUTISM & BEHAVIORAL SERVICES
ABA therapy and other behavioral health support for children and families.

PSYCHOLOGICAL TESTING
Testing and evaluation for ADHD, neurodivergence, OCD and more.

HIGHER LEVELS OF CARE
IOP, PHP, and residential treatment options when you need more support.

RESIDENTIAL CARE
Inpatient treatment for substance use and general mental health.

TMS & ADVANCED TREATMENTS
Transcranial Magnetic Stimulation (TMS) and other specialized treatment options.

CASE MANAGEMENT
Coordinating care and resources to improve outcomes and reduce stress.

PEER SUPPORT
Support from individuals with shared experiences who understand.

OUTCOMES TRACKING
Monitoring progress so your care continues to meet your needs.

HOW IT WORKS

1. REACH OUT
Call or email Patient Navigation.

2. CONNECT
Speak with a Licensed Care Navigator.

3. GET MATCHED
We find the right care for you—fast.

4. GET SUPPORT
Ongoing help through your healing journey.

WE'RE HERE FOR YOU.
Call your Patient Navigator at **423-824-2273**
or email **free@tcnavigator.com** for personalized support today.

You don't have to navigate it alone. We're with you.

*Members enrolled in an HSA-qualified High Deductible Health Plan (HDHP) must meet their deductible before benefitsapply,perplanterms.

Cylinder | Trinity Captive Group

Better health starts in the gut

Personalized gut health support—at no cost to you!

Cylinder is a no-cost digestive health program for members and dependents (18+) enrolled in a Trinity Captive Group-sponsored medical plan. Our team of experts provides real relief from gut issues like bloating, gas, heartburn, chronic conditions like IBS, and more.

This no-cost program includes the following and more:



- Microbiome test kit and analysis



- Virtual access to dedicated Registered Dietitians, Health Coaches, and Physicians



- Better overall physical and emotional wellbeing!

Explore more in the app
Live events, expert articles, on-demand courses, and easy tracking tools for food, symptoms, and progress.

Ready to see how Cylinder can help? Scan the QR code or visit:

Go.CylinderHealth.com/Trinity

Access code: Trinity

Questions? Contact us at (833) 336-9488 or support@cylinderhealth.com

FEDlogic

A free and confidential benefit from your employer.



Certain life events such as retirement, a serious diagnosis, or change in employment can open new options or resources.

FedLogic helps you and your household find and apply for the programs you qualify for, completely free.

Medicare	*Medicaid*	*Affordable Care*	*SSI*	*Disability*
Retirement	*Dialysis*	*Cancer*	*ALS*	*Premature Baby*
Veteran's Benefits	*Tribal Benefits*	*COBRA*	*Survivor's Benefits*	*Healthcare.gov*

Portal Access Code: okla25

employees.fedlogicgroup.com/form

Start with a short questionnaire and schedule a private consultation.

FEDlogic is sponsored by your employer. As an employee, our services are completely free, unlimited, and confidential to you and any member of your household.

FEDlogic

877-837-4196

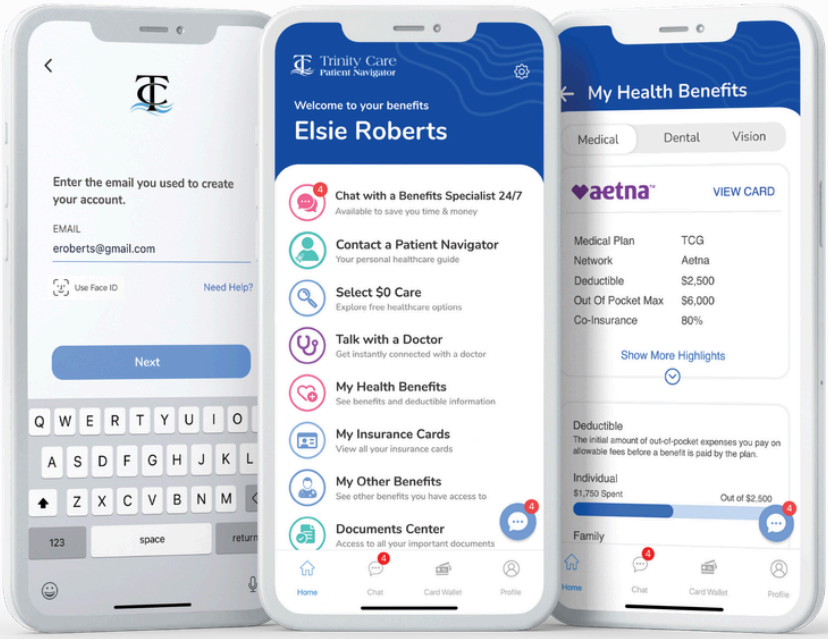
FEDLOGICGROUP.COM

SERVICES@FEDLOGICGROUP.COM

2509EQ

SET UP YOUR TC NAVIGATOR APP TODAY!

Whether you're trying to understand your coverage, find a provider, view your digital ID card, or manage your healthcare costs, the TC Navigator App is your all-in-one solution. Care Guides are available to help you get the most from your benefits, saving you time and money.



1 Getting started

Search ‘TC Navigator’ in the App Store (Apple) or Google Play (Android). Once downloaded, tap ‘Create Account.’

2 Creating an account

Follow the prompts after tapping "Create Account." You'll need your email address, date of birth, and the last 4 digits of your SSN.

3 Recover your account

Tap "Forgot Password?" Enter your last name (as it appears on your health insurance card), date of birth, and last 4 digits of your SSN.

4 Enable push notifications

Open your device settings and scroll until you find ***‘TC Navigator’*** in your list of apps and select it. Tap on ***‘Notifications’*** and toggle on ***‘Allow Notifications’.***

GET IT ON Google Play

Download on the App Store

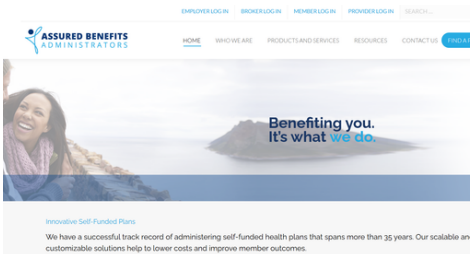
Enrolled employees and dependents age 18 and older who are enrolled in a health plan through TCG are eligible to create a TC Navigator account.

Access Your Information 24/7 With The Assured Benefits Member Portal

At Assured Benefits Administrators (ABA), our biggest priority is to give you the highest quality of service and to provide you with the easiest way possible to manage your health. Because of this, our Member Portal will allow you to quickly and easily see claims, deductibles and maximums, find a network provider, get a temporary ID card and much more, all in one convenient online location.

The portal and mobile app will provide multiple services:

- Access to Claim Statements/ Explanation of Benefits
- Digital ID Cards
- View expenses applied to your deductible and out-of-pocket maximums
- Find links to your provider locator websites



Register Here: https://portal.abadmin.com/Logon/

Registration

1. In the upper right corner of the Member Portal home screen, click Register Now

2. Fill out the Registration Form and click Submit.

Logging In

Once you have registered for the Member Portal, you may use your username and password to log in. The Login button is in the upper right corner of the Member Portal home screen.

An Important Note About Your Explanation of Benefits

Explanation of Benefits (EOBs) are no longer mailed to your home. You must register on the Member Portal and enter the email address that you wish to receive notifications to. You will receive an email every time a claim for you has been processed. You then simply log in to the Member Portal to access a copy of the EOB or download a report showing all your claims that have been processed for you and your covered dependents.

For plan questions or technical support, contact Patient Navigator at 423-TCG-CARE (423-824-2273) or email Free@TCNavigator.com.

**Please note, this portal can be accessed through the TC Navigator App.

Your 2027 Flexible Spending Account

Flexible Spending Accounts (FSAs) let you set aside pre-tax dollars from each paycheck for eligible health care and dependent care expenses for you, your spouse and your dependent children — lowering your taxable income.

Health Care / Limited Purpose FSA	Dependent Care FSA	Claims Deadline
$3,500	**$7,500**	**3/31/2028**
2027 annual maximum	per household ($3,750 if married filing separately)	for 2027 expenses

HOW IT WORKS

- You must enroll **each year**. Your annual election stays in effect January 1 – December 31, 2027.
- You can change your election only during open enrollment or if you have a qualifying change-in-status event.
- New employees must elect within **30 days** of hire or first date of benefits eligibility.
- See IRS Publication 502 at **irs.gov** for eligible expenses, or shop at **fsastore.com**.

HEALTH CARE & LIMITED PURPOSE FSA

Use pre-tax dollars for deductibles, medical and prescription copays, dental and vision expenses. Your **full annual election is available** as soon as your account is set up.

Limited Purpose FSA — for HSA participants

- If you open or contribute to an HSA, you may only enroll in the Limited Purpose FSA.
- If you enroll in the $3,900 HSA plan and elect a Health FSA, you'll automatically be enrolled in the Limited Purpose FSA.
- It reimburses dental and vision expenses only; you can't claim the same expense from both your FSA and HSA.

DEPENDENT CARE FSA

Pay for eligible dependent care with tax-free dollars so you and your spouse can work or attend school full time.

- Set aside up to **$7,500** per year ($3,750 if married filing separately).
- Funds are available only **after they are deposited** into your account.
- You can't use the same expenses for the dependent care tax credit on your tax return.

IMPORTANT FSA RULES

"USE IT" OR "LOSE IT"

Unused FSA funds do not roll over from year to year. Both the Health Care and Dependent Care FSA give you until **March 31, 2028** to submit claims for 2027 expenses.

ELIGIBLE DEPENDENT CARE

- Care for your dependent child under age 13 whom you claim on your federal tax return
- Care for a dependent child who lives with you and can't care for themselves
- Care for a spouse, parent or grandparent who can't care for themselves and spends at least 8 hours a day in your home

"Care" includes in-home babysitting (not by someone you claim as a dependent), licensed nursery or day care, before- and after-school care, summer day camp (not overnight) and in-home adult day care.

This is a summary only. 2027 limits are set by the IRS; please refer to OBU's plan documents for complete details. In the event of a conflict, the plan documents govern. Consult a tax advisor about your personal situation.

Your 2027 Health Savings Account

Enrolled in the $3,900 HSA plan? Take charge of your health care spending with a Health Savings Account (HSA) — a tax-free savings account that is yours to keep, no matter what.

Employee Only	Two-Person / Family	Catch-Up (55+)
$4,500	**$9,000**	**+$1,000**
2027 IRS maximum	2027 IRS maximum	per year

TRIPLE TAX ADVANTAGE

1 Tax-free in
Pre-tax contributions through payroll lower your taxable income.

2 Tax-free growth
Interest and investment earnings grow tax-free.

3 Tax-free out
Pay for qualified medical expenses with no tax.

UNDERSTANDING YOUR HSA

Feature	How It Works
Who can open one	Employees enrolled in the TCG $3,900 HSA plan who are not covered by other non-HSA medical coverage (such as a general-purpose FSA or Medicare) and can't be claimed as someone else's dependent
It's your money	Your HSA is owned by you and 100% vested from day one
Rolls over every year	Unused funds stay in your account — there is no "use it or lose it"
Goes with you	Your HSA stays with you if you change plans or employers. If you become ineligible to contribute, you can still spend your balance.
Change anytime	You may change your HSA contribution at any time during the year, for any reason
Qualified expenses	Deductibles, copays, prescriptions, dental and vision care for you, your spouse and tax dependents
Non-qualified use	Subject to income tax plus a 20% penalty (penalty does not apply after age 65, disability or death)

Pair it with a Limited Purpose FSA: Use the Limited Purpose FSA for dental and vision expenses and save your HSA dollars for medical costs — or let them grow for the future. You can't claim the same expense from both accounts.

Plan ahead: The contribution limit includes all contributions to your HSA from any source. The $1,000 catch-up applies if you are 55 or older by the end of 2027. Keep receipts for HSA withdrawals in case the IRS asks for them.

This is a summary only. See IRS Publication 969 at irs.gov for complete HSA rules. Limits are 2027 IRS maximums. If you enroll mid-year or lose eligibility during the year, your limit may be prorated. Consult a tax advisor about your personal situation.

Your 2027 Dental Plan Options

Both PPO plans let you see any dentist and include Principal's Maximum Rollover benefit. The Buy-Up Plan adds child orthodontia and pays more for root canals, oral surgery and gum care.

Plan Feature	Base Plan	Buy-Up Plan
Choice of dentist Save more with a Principal network dentist	Any licensed dentist	Any licensed dentist
Deductible Individual / Family — basic & major only	$100 / $300	$100 / $300
Annual maximum Per person, in & out of network combined	$1,000	$1,000
Maximum Rollover Grow your maximum to as much as $2,000	Up to +$1,000	Up to +$1,000
What the plan pays (in and out of network)		
Preventive Exams & cleanings (2 per year), x-rays, fluoride	100%	100%
Basic Fillings, sealants, emergency exams	80%	80%
Oral surgery, endodontics & periodontics Extractions, root canals, gum treatment	50%	80%
Major Crowns, bridges, dentures, implants	50%	50%
Orthodontia Dependent children; $1,500 lifetime maximum	Not covered	50%

HEALTHY HABITS GROW YOUR BENEFIT

1. **Get a checkup**
   Have at least one dental claim during the calendar year.
2. **Use less than $500**
   If Principal pays less than $500 in benefits for you that year, you qualify.
3. **$250 rolls over**
   Your rollover account can grow up to $1,000, for a total maximum of up to $2,000.

EXTRA PROGRAMS AT NO ADDITIONAL COST

- **Periodontal program:** extra cleaning or covered scaling for pregnancy, diabetes, heart disease or menopause
- **Second opinions** from dental providers covered at 100%
- **Cancer treatment oral health:** up to 3 fluoride treatments plus an extra cleaning
- **General anesthesia** coverage for members with certain conditions

Good to know: Out-of-network benefits are based on the 99th percentile of usual and customary charges, so you can see the dentist of your choice. Network dentists agree to lower fees and won't bill you the difference.

This is a summary only. Frequency limits apply. Orthodontia covers dependent children with bands placed before age 19. Please refer to the Principal benefit summary and booklet for complete details, limitations and exclusions. See the Employee Contributions page for your cost. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Healthy Habits Grow Your Dental Benefit

With Principal's Maximum Rollover benefit, members who use their dental plan lightly can carry part of their unused annual maximum into the next year — growing their maximum by up to $1,000.

HOW IT WORKS

1 See your dentist
Have at least one dental claim during the calendar year — a routine exam and cleaning counts.

2 Use less than $500
If Principal pays less than $500 in benefits for you that year, you qualify.

3 $250 rolls over
$250 is added to your rollover account and boosts next year's maximum.

4 Build to +$1,000
Keep it up — your rollover account can grow to $1,000 above your base maximum.

WHAT IT COULD MEAN FOR YOU

Base Plan
Principal PPO

Base annual maximum	**$1,000**
Preventive / Basic / Major	**100 / 80 / 50%**
Orthodontia	**Not covered**

Up to $2,000
annual maximum with rollover

$1,000 Start › **$1,250** +$250 › **$1,500** +$500 › **$1,750** +$750 › **$2,000** +$1,000

Buy-Up Plan
Principal PPO

Base annual maximum	**$1,000**
Preventive / Basic / Major	**100 / 80 / 50%**
Orthodontia	**50% • $1,500 lifetime**

Up to $2,000
annual maximum with rollover

$1,000 Start › **$1,250** +$250 › **$1,500** +$500 › **$1,750** +$750 › **$2,000** +$1,000

Why it matters: Preventive care is covered at 100%, so routine checkups cost you little and help your maximum grow — leaving more room for fillings, crowns and other care when you need it. Because OBU's dental plan is staying with Principal for 2027, any rollover amount you have already earned stays with you.

Don't lose it: Your entire rollover balance is forfeited if no dental claim is submitted during a calendar year. A yearly checkup keeps your balance active.

Maximum Accumulation (Rollover) criteria: the threshold is the lesser of 50% of the out-of-network annual maximum or $1,000 ($500 for OBU's plans), and the rollover amount is 50% of the threshold ($250). Accumulation is limited to four times the rollover amount ($1,000). Members with fourth-quarter effective dates begin qualifying at the start of the next calendar year. Illustration assumes criteria are met each year; actual benefits are subject to plan terms, deductibles ($100 individual / $300 family, basic & major services) and the calendar year maximum. Orthodontia on the Buy-Up Plan is for dependent children only. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Your 2027 Vision Plan

See a VSP network doctor for your yearly eye exam and get help paying for glasses or contact lenses — all at low out-of-pocket costs. Coverage is through Principal using the VSP Choice network.

Eye Exam	Lenses	Frames	Contacts
$10 copay	**$25** copay	**$200** allowance	**$200** allowance

YOUR VSP CHOICE NETWORK COVERAGE

Benefit	Your Cost (in network)	How Often	Out of Network
Eye exam	**$10 copay**	Every 12 months	Up to $45
Lenses Single, lined bifocal, trifocal, lenticular	**$25 copay** (polycarbonate covered for children under 18)	Every 12 months	$30 / $50 / $65 / $100
Standard progressive lenses	**$0 copay**; other enhancements average 30% savings	Every 12 months	—
Frames	**$200 allowance**, 20% off amount over ($110 at Costco®, Walmart®, Sam's Club®)	Every 12 months	Up to $70
Elective contacts Instead of glasses	**$200 allowance**; fitting & evaluation up to $60 copay	Every 12 months	Up to $105
Necessary contacts	Covered in full after **$25 copay**	Every 12 months	Up to $210

YOUR COST

Coverage Level	Monthly Cost	Per Paycheck (semi-monthly)
Employee Only	**$11.77**	$5.89
Employee + Spouse	**$18.85**	$9.43
Employee + Child(ren)	**$19.23**	$9.62
Employee + Family	**$31.02**	$15.52

USING YOUR BENEFITS IS EASY

1. **Find a doctor**
   Go to vsp.com and choose the "Choice" network.
2. **Schedule your exam**
   Tell the office you have VSP — they'll file the claim.
3. **Save even more**
   20–25% off extra glasses and sunglasses, plus LASIK discounts.

This is a summary only. Vision coverage is offered through Principal® with the VSP® Choice network. Non-prescription glasses and medical or surgical eye treatment are not covered. Savings may vary by state law and provider location. Rates are guaranteed through 12/31/2027; per-paycheck amounts are Principal's semi-monthly estimates. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Find a VSP doctor: **vsp.com** | **800-877-7195**

Your 2027 Basic Life & AD&D

OBU provides Basic Life and Accidental Death & Dismemberment (AD&D) insurance through Principal at no cost to you. New for 2027: your coverage moves to Principal with the same great benefits.

Your Cost	Life Benefit	Maximum	AD&D
$0	**1x**	**$200,000**	**Match**
100% paid by OBU	annual salary	minimum $30,000	equal to your life benefit

YOUR BASIC LIFE & AD&D COVERAGE

Plan Feature	What You Get
Who is eligible	All active, full-time employees working at least 30 hours per week
Life benefit Rounded to the next higher $1,000	100% of your annual salary — minimum $30,000, maximum $200,000
Accidental Death & Dismemberment (AD&D)	Additional benefit equal to your life benefit if death or a covered injury results from an accident, on or off the job
Guaranteed issue	Under age 70: $200,000 — no health questions required
Age reduction schedule	Your coverage reduces to **65%** at age 65 and **50%** at age 70
Accelerated death benefit	If terminally ill (life expectancy of 12 months or less), you may receive up to 75% of your life benefit, up to $250,000
Coverage during disability	If you become totally disabled before age 60, coverage may continue with premium waived after 9 months
Conversion	When coverage ends, you may convert to an individual policy without proof of good health

EXTRA AD&D BENEFITS

Seatbelt / Airbag
$10,000 if you die in a car accident while wearing a seatbelt or protected by an airbag

Education
$3,000 per year for up to 4 years for children enrolled in an accredited post-secondary school

Repatriation
Up to $2,000 if death occurs at least 100 miles from home

Keep your beneficiaries up to date. Your beneficiary is the person who receives your life insurance benefit. Name both a primary and a contingent beneficiary, and review your choices whenever your life changes — marriage, divorce, a new child or the loss of a loved one.

Included at no cost: Travel assistance when you are 100+ miles from home, a Will & Legal Document Center (ARAG®), an identity theft resource kit and beneficiary support services (Empathy). These services are not insurance.

This is a summary only. Please refer to the Principal benefit summary and booklet for complete details, limitations and exclusions. AD&D benefits for other covered losses (such as loss of a hand, foot or sight) are a percentage of the life benefit. In the event of a conflict, the policy governs. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Your 2027 Voluntary Life & AD&D

Add extra protection for yourself and your family beyond the Basic Life coverage OBU provides. Coverage is through Principal, and AD&D is automatically included with every life amount you elect.

Employee	Spouse	Child(ren)	AD&D
$500,000	**$100,000**	**$10,000**	**Included**
$10,000 increments	$5,000 increments*	per child, to age 26	equal to life benefit

COVERAGE OPTIONS

Coverage	Benefit Options	Guaranteed Issue (no health questions)**
You	$10,000 to $500,000 in $10,000 increments	Under age 70: **$200,000** Age 70+: $10,000
Your Spouse	$5,000 to $100,000 in $5,000 increments; may not exceed 50% of your benefit	Under age 70: **$30,000** Age 70+: $10,000
Your Child(ren)	$10,000 per child, to age 26 (children under 14 days old receive $1,000)	Guaranteed

PLAN PROVISIONS

Feature	Details
Cost of coverage	Paid by you through post-tax payroll deduction. Employee and spouse rates are based on each person's own age. See the rate grids on the following pages.
Who is eligible	Active, full-time employees working at least 30 hours per week. You must elect coverage for yourself to cover your spouse or children.
Annual increase option	Each open enrollment, you may enroll or increase your coverage (and your dependents') by up to **two increments** without health questions, up to the plan maximum.
Age reduction	None — your benefit does not reduce with age
Portability	If you leave OBU, you may continue coverage for yourself and covered dependents until age 70
Additional features	Accelerated death benefit (up to 75%, max $250,000, if terminally ill); premium waiver if totally disabled before age 60; conversion to an individual policy when coverage ends

Guaranteed Issue (GI) and Evidence of Insurability (EOI): **When you are first eligible, you may elect up to the GI amounts within 31 days without providing health information. Amounts above GI — or coverage requested later outside the annual increase option — require EOI and approval by Principal before they take effect.

*Spouse coverage may not exceed 50% of the employee's coverage. If you and your spouse both work at OBU, you may not be covered as both an employee and a spouse. This is a summary only; refer to the Principal benefit summary and booklet for complete details, limitations and exclusions. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Employee Rate Grid

Voluntary Life & AD&D — $10,000 to $500,000 in $10,000 increments. Guaranteed issue up to $200,000 (under age 70) when you first become eligible.

EMPLOYEE MONTHLY RATES PER $1,000

Age	Life	AD&D	Total
Under 30	$0.046	$0.017	**$0.063**
30-34	$0.061	$0.017	**$0.078**
35-39	$0.076	$0.017	**$0.093**
40-44	$0.100	$0.017	**$0.117**
45-49	$0.150	$0.017	**$0.167**
50-54	$0.230	$0.017	**$0.247**
55-59	$0.421	$0.017	**$0.438**
60-64	$0.635	$0.017	**$0.652**
65-69	$1.020	$0.017	**$1.037**
70+	$1.928	$0.017	**$1.945**

HOW TO CALCULATE YOUR COST

1. Find the total rate for your age.
2. Divide the coverage amount by $1,000.
3. Multiply the two numbers.

Example: $100,000 at age 42
100 × $0.117 = **$11.70 per month**

Child(ren): $10,000 per child for **$2.00 per month** — one premium covers all of your eligible children.

EMPLOYEE MONTHLY PREMIUM — LIFE + AD&D (12 PAYROLL DEDUCTIONS PER YEAR)

Benefit	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.63	$0.78	$0.93	$1.17	$1.67	$2.47	$4.38	$6.52	$10.37	$19.45
$20,000	$1.26	$1.56	$1.86	$2.34	$3.34	$4.94	$8.76	$13.04	$20.74	$38.90
$30,000	$1.89	$2.34	$2.79	$3.51	$5.01	$7.41	$13.14	$19.56	$31.11	$58.35
$40,000	$2.52	$3.12	$3.72	$4.68	$6.68	$9.88	$17.52	$26.08	$41.48	$77.80
$50,000	$3.15	$3.90	$4.65	$5.85	$8.35	$12.35	$21.90	$32.60	$51.85	$97.25
$60,000	$3.78	$4.68	$5.58	$7.02	$10.02	$14.82	$26.28	$39.12	$62.22	$116.70
$70,000	$4.41	$5.46	$6.51	$8.19	$11.69	$17.29	$30.66	$45.64	$72.59	$136.15
$80,000	$5.04	$6.24	$7.44	$9.36	$13.36	$19.76	$35.04	$52.16	$82.96	$155.60
$90,000	$5.67	$7.02	$8.37	$10.53	$15.03	$22.23	$39.42	$58.68	$93.33	$175.05
$100,000	$6.30	$7.80	$9.30	$11.70	$16.70	$24.70	$43.80	$65.20	$103.70	$194.50
$150,000	$9.45	$11.70	$13.95	$17.55	$25.05	$37.05	$65.70	$97.80	$155.55	$291.75
$200,000	$12.60	$15.60	$18.60	$23.40	$33.40	$49.40	$87.60	$130.40	$207.40	$389.00
$250,000	$15.75	$19.50	$23.25	$29.25	$41.75	$61.75	$109.50	$163.00	$259.25	$486.25
$300,000	$18.90	$23.40	$27.90	$35.10	$50.10	$74.10	$131.40	$195.60	$311.10	$583.50
$350,000	$22.05	$27.30	$32.55	$40.95	$58.45	$86.45	$153.30	$228.20	$362.95	$680.75
$400,000	$25.20	$31.20	$37.20	$46.80	$66.80	$98.80	$175.20	$260.80	$414.80	$778.00
$450,000	$28.35	$35.10	$41.85	$52.65	$75.15	$111.15	$197.10	$293.40	$466.65	$875.25
$500,000	$31.50	$39.00	$46.50	$58.50	$83.50	$123.50	$219.00	$326.00	$518.50	$972.50

Rates are monthly and include Life and AD&D. Employee rates are based on your age and change when you move into a new age band. Premiums shown are for illustration; your actual payroll deduction is determined by Principal and OBU. Rates are guaranteed for 36 months. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Spouse Rate Grid

Voluntary Life & AD&D — $5,000 to $100,000 in $5,000 increments, not to exceed 50% of the employee's benefit. Guaranteed issue up to $30,000 (under age 70).

SPOUSE MONTHLY RATES PER $1,000

Age	Life	AD&D	Total
Under 30	$0.046	$0.017	**$0.063**
30-34	$0.061	$0.017	**$0.078**
35-39	$0.076	$0.017	**$0.093**
40-44	$0.100	$0.017	**$0.117**
45-49	$0.150	$0.017	**$0.167**
50-54	$0.230	$0.017	**$0.247**
55-59	$0.421	$0.017	**$0.438**
60-64	$0.635	$0.017	**$0.652**
65-69	$1.020	$0.017	**$1.037**
70+	$1.928	$0.017	**$1.945**

HOW TO CALCULATE YOUR COST

1. Find the total rate for your spouse's age.
2. Divide the coverage amount by $1,000.
3. Multiply the two numbers.

Example: $25,000, spouse age 42
25 × $0.117 = **$2.93 per month**

Child(ren): $10,000 per child for **$2.00 per month** — one premium covers all of your eligible children.

SPOUSE MONTHLY PREMIUM — LIFE + AD&D (12 PAYROLL DEDUCTIONS PER YEAR)

Benefit	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$0.32	$0.39	$0.47	$0.59	$0.84	$1.24	$2.19	$3.26	$5.19	$9.73
$10,000	$0.63	$0.78	$0.93	$1.17	$1.67	$2.47	$4.38	$6.52	$10.37	$19.45
$15,000	$0.95	$1.17	$1.40	$1.76	$2.51	$3.71	$6.57	$9.78	$15.56	$29.18
$20,000	$1.26	$1.56	$1.86	$2.34	$3.34	$4.94	$8.76	$13.04	$20.74	$38.90
$25,000	$1.58	$1.95	$2.33	$2.93	$4.18	$6.18	$10.95	$16.30	$25.93	$48.63
$30,000	$1.89	$2.34	$2.79	$3.51	$5.01	$7.41	$13.14	$19.56	$31.11	$58.35
$50,000	$3.15	$3.90	$4.65	$5.85	$8.35	$12.35	$21.90	$32.60	$51.85	$97.25
$75,000	$4.73	$5.85	$6.98	$8.78	$12.53	$18.53	$32.85	$48.90	$77.78	$145.88
$100,000	$6.30	$7.80	$9.30	$11.70	$16.70	$24.70	$43.80	$65.20	$103.70	$194.50

Rates are monthly and include Life and AD&D. Spouse rates are based on your spouse's age and change when your spouse moves into a new age band. Premiums shown are for illustration; your actual payroll deduction is determined by Principal and OBU. Rates are guaranteed for 36 months. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Questions? **principal.com** | Contact OBU Human Resources

Your 2027 Long-Term Disability

If a serious illness or injury keeps you from working for an extended period, Long-Term Disability (LTD) replaces part of your income. OBU pays the full cost. New for 2027: LTD moves to Principal with the same benefits.

Your Cost	Benefit	Maximum	Benefits Begin
$0	**60%**	**$8,000**	**90 days**
100% paid by OBU	of monthly base earnings	per month	elimination period

YOUR LONG-TERM DISABILITY COVERAGE

Plan Feature	What You Get
Who is eligible	All active, full-time employees working at least 30 hours per week
Monthly benefit	60% of your monthly base earnings, up to $8,000 per month (minimum $100), reduced by other income sources such as Social Security or workers' compensation
Elimination period Time you must be disabled before benefits begin	90 days
Definition of disability	Own occupation for the first 2 years; after that, any occupation for which you are reasonably qualified by education, training or experience
Benefit duration	If disabled before age 65: to the later of Social Security Normal Retirement Age or 36 months. Shorter periods apply if disabled at age 65 or older.
Mental health, drug & alcohol, special conditions	Benefits limited to a combined lifetime maximum of 24 months
Pre-existing conditions	3 months prior / 12 months insured
Definition of earnings	Base wage

ADDED SUPPORT

Work incentive
Return to work part-time and keep receiving a benefit for up to 12 months.

Rehabilitation
Return-to-work planning, plus a 5% benefit increase for completing an approved plan.

Survivor benefit
Your survivors receive 3 times your monthly benefit if you pass away while on claim.

Also included with your LTD coverage: a confidential Employee Assistance Program through ComPsych® GuidanceResources®, LASIK savings and hearing aid discounts. These services are not insurance.

This is a summary only. Other income sources, limitations and exclusions apply; please refer to the Principal benefit summary and booklet for complete details. In the event of a conflict, the policy governs. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Principal® | Employee Assistance Program

Oklahoma Baptist University
Plan Year January 1 – December 31, 2027

Your Enhanced EAP: Support for Life

New for 2027: a free, confidential Employee Assistance Program through Principal and ComPsych® GuidanceResources®. Get support for life's challenges, big or small — for you and your family.

Your Cost	Counseling	Availability	Privacy
$0	**5 sessions**	**24/7**	**100%**
provided by OBU	per person, per issue, per year	phone, web, app	confidential

WHAT'S INCLUDED

Confidential Counseling
- Anxiety, depression and stress
- Grief, loss and life adjustments
- Relationship and marital conflicts
- In person, by phone, video, chat or text

Work-Life Support
- Child, elder and pet care referrals
- Moving and relocation help
- Housing searches and community resources

Legal Guidance
- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local attorney representation

Financial Resources
- Budgeting, debt and bankruptcy
- Retirement, taxes and mortgages
- Identity theft resources

Well-Being Coaching
- One-on-one coaching for positive lifestyle changes
- Mindfulness, nutrition, sleep and exercise
- Smoking cessation and weight management

Digital Tools
- GuidanceNow℠ app with immediate connection to support
- Guided behavioral health programs
- Articles, videos and self-care tools

GETTING STARTED IS EASY

1

Call anytime
833.955.3389 (TRS: dial 711) to speak with a caring professional, 24/7.

2

Go online
Visit guidanceresources.com and register with OBU's Web ID (available from HR).

3

Get the app
Download GuidanceNow℠ for support wherever you are.

Who can use it: You and your household family members. Assistance is always confidential.

The Employee Assistance Program is provided by ComPsych® and made available through OBU's group coverage with Principal Life Insurance Company®. EAP is not insurance, is not part of the insurance policy and may be changed or discontinued at any time. ComPsych is not a member of the Principal Financial Group®. If you are in crisis or need immediate help, call 911 or 988.

Your 2027 Accident Insurance

Accidents happen — at home, at work or at play. Accident insurance pays you a cash benefit for covered injuries to help with costs your medical plan doesn't cover. Use it however you need.

Coverage	Fractures	Dislocations	Accidental Death
24/7	**$10,000**	**$7,500**	**$25,000**
on and off the job	up to	up to	employee

SAMPLE INJURY BENEFITS

Injury	Surgical	Non-surgical
Fracture: hip, skull, thigh	$10,000	$5,000
Fracture: lower leg, pelvis, vertebrae	$5,000	$2,500
Fracture: ankle, arm, wrist, hand, foot	$3,000	$1,500
Fracture: rib, tailbone	$1,000	$500
Dislocation: hip	$7,500	$3,750
Dislocation: knee	$5,000	$2,500
Dislocation: ankle, elbow, shoulder, wrist	$3,000	$1,500

OTHER BENEFITS

Injury	Benefit
Burns (2nd / 3rd degree)	$500 – $5,000
Coma	$15,000
Concussion	$500
Dental injury	$500
Eye injury with surgery	$500
Internal injury	$1,500
Torn knee cartilage, ruptured disc, tendon/ligament/rotator cuff with surgery	$1,500
Injuries not listed	$100

ACCIDENTAL DEATH & DISMEMBERMENT

You: $25,000
Spouse $12,500 • Children $6,250. Partial benefits for dismemberment and paralysis.

Common carrier
Additional 200% if death occurs as a passenger on public or commercial transportation.

Youth sports
Extra 25% (up to $1,000 per year) for children 18 and under hurt in organized youth sports.

YOUR COST

Coverage Level	Monthly Cost	Per Paycheck (semi-monthly)
Employee Only	$7.86	$3.93
Employee + Spouse	$11.60	$5.80
Employee + Child(ren)	$13.86	$6.93
Employee + Family	$20.92	$10.46

ACCIDENT INSURANCE PROVIDES LIMITED BENEFITS. This is a summary only. One benefit per injury type is payable per accident unless noted; multiple fractures/dislocations pay up to 200% of the highest benefit. Coverage is portable if you leave OBU. Limitations and exclusions apply; see the Principal booklet. Rates are guaranteed through 12/31/2027; per-paycheck amounts are Principal's semi-monthly estimates. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Your 2027 Critical Illness Insurance

A serious diagnosis can bring unexpected costs. Critical illness insurance pays you a lump-sum benefit when you're diagnosed with a covered illness — use it for medical bills, travel, the mortgage or anything you need.

COVERAGE OPTIONS

Who	Benefit	Guaranteed Issue
You	$5,000 – $100,000 in $5,000 increments	**$30,000**
Spouse	$2,500 – $50,000 in $2,500 increments, up to 50% of yours	**$15,000**
Children	Automatically 25% of your benefit	No cost

COVERED ILLNESSES (FIRST DIAGNOSIS)

Condition	Benefit
Invasive cancer, heart attack, stroke, major organ failure*	**100%**
Alzheimer's, ALS, MS, Parkinson's, benign brain tumor, coma, paralysis, loss of sight, speech or hearing	**100%**
Carcinoma in situ, coronary artery disease*	**25%**
Skin cancer	**$250**

Also covered: childhood conditions such as cerebral palsy, cystic fibrosis and Down syndrome (100%); 15 infectious diseases with a 3+ day hospital stay (25%); bipolar I, PTSD and schizophrenia (25%); complications of pregnancy and infertility (25%). *These conditions can pay again for an additional occurrence. **Health screening benefit:** $50 per covered person, once per year.

MONTHLY COST — EMPLOYEE OR SPOUSE (BASED ON EACH PERSON'S AGE)

Benefit	≤24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Per $1,000	**$0.141**	**$0.207**	**$0.325**	**$0.387**	**$0.541**	**$0.777**	**$1.157**	**$1.616**	**$2.342**	**$3.323**	**$4.828**
$5,000*	$0.71	$1.04	$1.63	$1.94	$2.71	$3.89	$5.79	$8.08	$11.71	$16.62	$24.14
$10,000*	$1.41	$2.07	$3.25	$3.87	$5.41	$7.77	$11.57	$16.16	$23.42	$33.23	$48.28
$15,000*	$2.12	$3.11	$4.88	$5.81	$8.12	$11.66	$17.36	$24.24	$35.13	$49.85	$72.42
$20,000*	$2.82	$4.14	$6.50	$7.74	$10.82	$15.54	$23.14	$32.32	$46.84	$66.46	$96.56
$25,000*	$3.53	$5.18	$8.13	$9.68	$13.53	$19.43	$28.93	$40.40	$58.55	$83.08	$120.70
$30,000*	$4.23	$6.21	$9.75	$11.61	$16.23	$23.31	$34.71	$48.48	$70.26	$99.69	$144.84
$50,000	$7.05	$10.35	$16.25	$19.35	$27.05	$38.85	$57.85	$80.80	$117.10	$166.15	$241.40
$75,000	$10.58	$15.53	$24.38	$29.03	$40.58	$58.28	$86.78	$121.20	$175.65	$249.23	$362.10
$100,000	$14.10	$20.70	$32.50	$38.70	$54.10	$77.70	$115.70	$161.60	$234.20	$332.30	$482.80

Need a different amount? Multiply your rate per $1,000 by the benefit ÷ 1,000. Example: $35,000 at age 42 = 35 × $0.541 = **$18.94/month**.

*Amounts up to $30,000 (you) and $15,000 (spouse) require no health questions when first eligible. Per-paycheck (semi-monthly) cost is half the monthly amount.

CRITICAL ILLNESS INSURANCE PROVIDES LIMITED BENEFITS. This is a summary only. Pre-existing conditions: 6 months prior / 12 months insured. A different illness is payable if diagnosed more than 12 months after a prior illness. Late enrollment or increases are allowed only at open enrollment and may require health information. Coverage is portable. Rates are guaranteed through 12/31/2027 and change when you move into a new age band at the policy anniversary. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Your 2027 Hospital Indemnity Insurance

A hospital stay can be expensive. Hospital indemnity insurance pays you cash when you or a covered family member is admitted — to help with deductibles, coinsurance or everyday bills.

Hospital Admission	ICU Admission	Daily Hospital	Daily ICU
$1,000	**$2,000**	**$100**	**$200**
first day, 1 per year	first day, 1 per year	per day, up to 30 days	per day, up to 30 days

WHAT THE PLAN PAYS

Benefit (sickness or injury)	Benefit Amount	Maximum
First day hospital	$1,000	1 day per year
First day ICU	$2,000	1 day per year
Daily hospital	$100	30 days per year
Daily ICU	$200	30 days per year
Newborn nursery	$100	1 day per year
Health screening benefit	$50	Once per year, per person

Whole family covered

Your spouse and children receive 100% of your benefit amounts.

Pregnancy included

Childbirth is treated like any other sickness, plus a newborn nursery benefit.

HSA compatible

Works alongside the $3,900 HSA plan. Consult your tax advisor.

YOUR COST

Coverage Level	Monthly Cost	Per Paycheck (semi-monthly)
Employee Only	$14.92	$7.46
Employee + Spouse	$34.82	$17.41
Employee + Child(ren)	$24.26	$12.13
Employee + Family	$45.92	$22.96

How it works: Benefits are paid directly to you, regardless of what your medical plan pays. Use the cash for deductibles, coinsurance, travel, childcare or household bills.

HOSPITAL INDEMNITY INSURANCE PROVIDES LIMITED BENEFITS. This is a summary only. A minimum of 18 consecutive hours of confinement is required. Pre-existing conditions: 12 months prior / 12 months insured. You must enroll within 31 days of eligibility or wait until open enrollment unless you have a qualifying life event. Coverage is portable. Rates are guaranteed through 12/31/2027; per-paycheck amounts are Principal's semi-monthly estimates. Insurance issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Your 2027 Monthly Contributions

Here's what you'll pay each month for the coverage you choose. Compare your medical and dental options and pick the plans that best fit you and your family.

MEDICAL — TRINITY CAPTIVE GROUP

Coverage Level	$3,000 PPO		$3,900 HSA	
	Jan – May	Jun – Dec	Jan – May	Jun – Dec
Employee Only	$118.14	$128.82	$107.42	$117.18
Employee + Spouse	$404.42	$441.18	$368.28	$401.76
Employee + Child(ren)	$365.54	$398.78	$332.82	$363.06
Employee + Family	$577.64	$630.18	$525.82	$573.62

DENTAL — PRINCIPAL

Coverage Level	Base Plan	Buy-Up Plan
Employee Only	$5.88	$16.36
Employee + Spouse	$19.42	$37.02
Employee + Child(ren)	$22.00	$61.02
Employee + Family	$33.30	$82.84

Amounts shown are monthly employee contributions for the plan year January 1 – December 31, 2027. Medical: Jan – May rates apply January 1 – May 31, 2027; Jun – Dec rates apply June 1 – December 31, 2027. Your per-paycheck deduction depends on OBU's payroll schedule. Please contact OBU Human Resources with questions.

CONTACTS

HUMAN RESOURCES - Shelly Tombleson

Phone: 405-585-5161

Email: shelly.tombleson@okbu.edu

PATIENT NAVIGATOR

Benefits, Claims, Pharmacy & Free Services

Phone: 423-TCG-CARE (423-824-2273)

Email: Free@TCNavigator.com

CALL-A-DOC- TELEMEDICINE

Phone: (844) 362-2447

Online: www.247calladoc.com

PHARMACY BENEFITS (VERUSRX)

Help Desk: 800-838-0007

Mail Order & Specialty Pharmacy: 800-838-0007

Online: www.verus-rx.com



REQUIRED NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents 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). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you

may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

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

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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in 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 the 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 through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. We have determined that the prescription drug coverage offered to our employees is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

   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 prescription drug plan, as long as you later enroll within specific time periods.

   You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription 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).

   You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the 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 Human Resources.

If you choose to enroll in a Medicare prescription drug plan and cancel your current employer provided 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. If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month. that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also 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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800-772-1213. TTY users should call 800- 325-0778.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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).

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL NFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Effective Date of Notice: **August 11, 2025**

Your employer’s Rx's Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. Who to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating physician the name of your treating radiologist so the physician can get your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations). For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing

functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes. For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to the disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After that, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease /condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (e.g., to investigate complaints against providers); and other activities necessary for the oversight of government benefit programs (e.g. Medicare or Medicaid fraud).

The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

1. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

2. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
3. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law. Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI . However, the Plan is not required to agree to your request (except the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for services to which the information relates in full, out of pocket.)

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official. If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Plan's Privacy Official. You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made:

(1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI ; (3) pursuant to your authorization; (4)

prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for

certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
1. a court order of appointment of the person as the conservator or guardian of the individual; or
2. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective **August 11, 2025**, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the

changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI . The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI , the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants’ PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI , the Plan will notify affected individuals of the breach.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to Human Resources.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 are 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 and CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual 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, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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 are not 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, 2016. Contact your State for further information on eligibility.

ALABAMA - Medicaid
Website: http://www.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: http://dhss.alaska.gov/dpa/Pages/medicaid/ default.aspx

COLORADO - Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com
Member Contact Center: 1-800-221-394
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plusCHP+
Customer Service: 1-800-359-1991 / State Relay 711

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com
Phone: 1-877-357-3268

GEORGIA - Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479

All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0964

IOWA - Medicaid
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

KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

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
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

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

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

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website:
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

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

NEW HAMPSHIRE - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY - Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

OREGON - Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND - Medicaid
Website: www.eohhs.ri.gov
Phone: 401-462-5300

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

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

TEXAS - Medicaid
Website: http://www.gethipptexas.com/
Phone: 1-800-440-0493

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

VERMONT- Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON - Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA - Medicaid
Website: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN -Medicaid
Website: http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any more States have added a premium assistance programs since January 31, 2020, or for more information on special enrollment rights, you can contact either:
U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/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

Continuation of Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

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.

- 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.“

  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 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.

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.