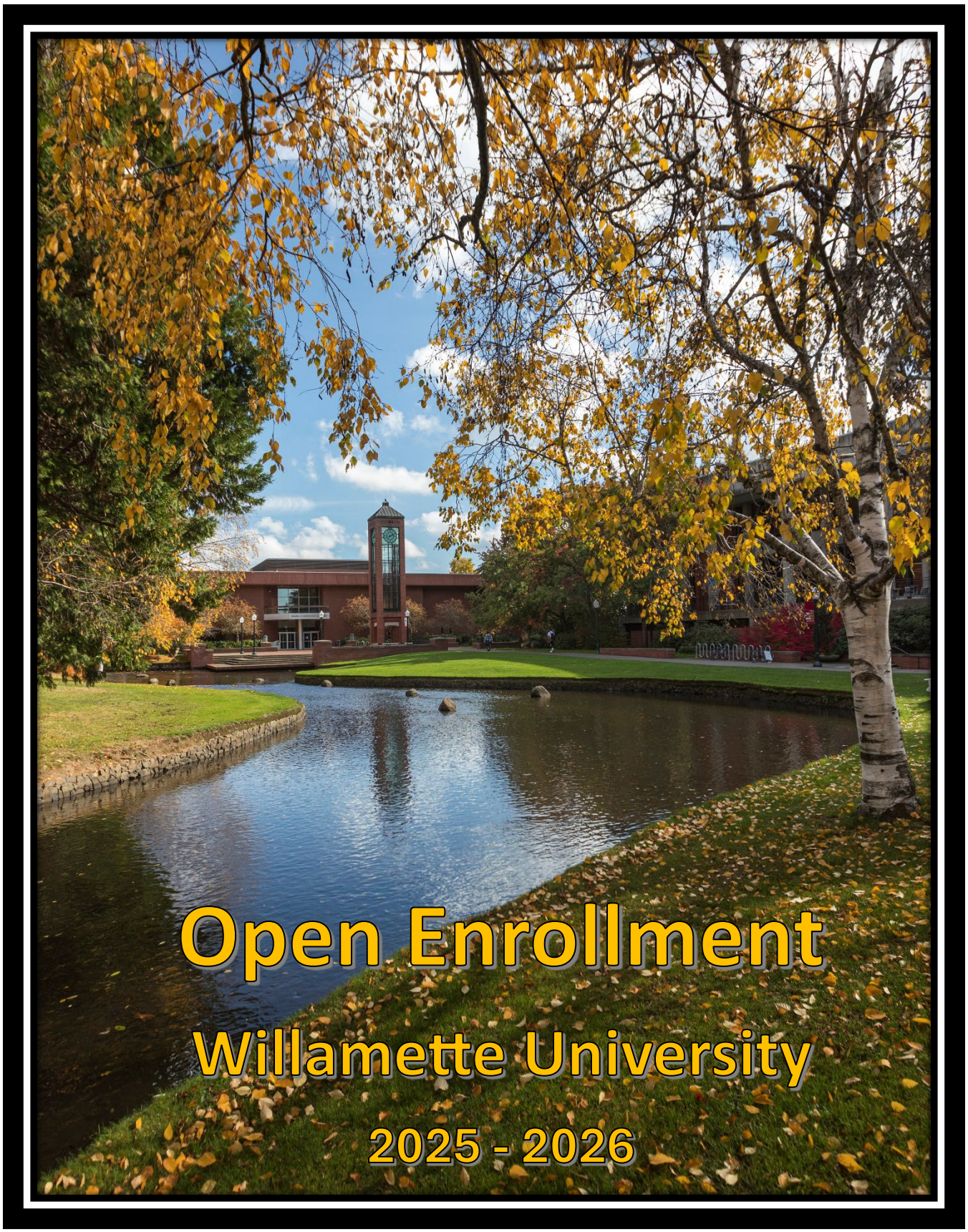
Open Enrollment
Willamette University
2025 - 2026

Open Enrollment: February 10 – February 28, 2025

Open Enrollment is a time to evaluate your healthcare options and determine the plan that best suits you and your family's needs for the 2025-26 plan year. It is also the one time during the year when you can add or remove eligible family members and change or enroll in benefits that are not always open for enrollment without a qualifying life event. **Note: you can elect to enroll in the transit flexible spending account and the voluntary retirement plans at any time.*

Your Open Enrollment Checklist:

- ☐ **Review Your Current Benefit Elections:** If you are satisfied with your current plans, there is nothing more you need to do, unless you participate or plan to participate in a medical or dependent care flexible spending account as described below.

- ☐ **Enroll/Re-Enroll in a Medical or Dependent Care Flexible Spending Account:** All employees currently enrolled in a medical or dependent care flexible spending account **must** complete a new election in Workday for the new plan year if you wish to continue your flexible spending account(s). If you do not re-enroll, you will not have a flexible spending account in 2025-26.

- ☐ **Review & Update Address Information:** Please ensure the address we have on file in Workday is correct, so you receive important benefits related items such as insurance cards and required notices.

- ☐ **Review & Update Emergency Contact Information:** Readily available contact information can be a lifesaver in the event of a medical emergency at work. Please review and/or update your emergency contact information in Workday.

- ☐ **Review & Update Beneficiary Information:** Each year it is good practice to review your life insurance and retirement plan beneficiaries and make any necessary changes.

Overview of Changes for the 2025-2026 Plan Year:

- **Medical Premium Changes – Kaiser HMO:** Overall cost for medical insurance through Kaiser's HMO is increasing by 10% this year. Employees enrolled in the HMO plan will have a commensurate 10% increase in employee contributions. The one exception is the Kaiser HMO employee only coverage for those making under $50,000, which will remain at no cost to the employee.
- **Medical Premium Changes** – **Kaiser PPO:** Under the PPO plan, Kaiser continues to pay out more in claims for our employees than it collected in premiums. As expected, the PPO premiums will also increase by 10%. Employees enrolled in the PPO plan will have a commensurate 10% increase in employee contributions. Please refer to the rate chart on page 5 to see plan pricing.
- **Dental Premium Changes** – Dental premiums for the Kaiser DHMO plan will decrease by 2%. Dental premiums for The Standard PPO plan will increase by 5%.
- **Medical and Transit Flexible Spending Account Changes:** The IRS increased the maximum annual contribution to medical flexible spending accounts from $3,200 to $3,300. The transit account annual limit increased from $315 to $325 for 2025.
- **Medical Flexible Spending Account Balance Rollover:** The IRS increased the rollover limit for unused funds from $640 to $660 for 2025.
- **LegalShield Price Changes:** The price for Individual LegalShield plans and Individual LegalShield/IDShield plans will increase by $2.00. Individual LegalShield plans will now be $18.95 per month and Individual LegalShield/IDShield plans will now be $27.90 per month.

Frequently Asked Questions (FAQs)

Can I switch plans?

Yes, during the Open Enrollment period. Changes and enrollments need to be submitted online by **Friday, February 28, 2025, at 5:00 PM** in Workday.

Will my deductible and out-of-pocket maximums increase?

No, there are no deductible or out-of-pocket maximum changes for the 2025-26 plan year.

Will my premium increase?

Yes. The employer and employee portion of medical and The Standard dental premiums are increasing for the 2025-26 benefit plan year. However, the university will still cover 100% of the premium for employee-only healthcare coverage under the HMO plan for employees earning less than $50,000 annually. For medical and dental plan rates, please go to page 5.

When will the selections I make during Open Enrollment take effect?

Benefit plan elections and beneficiary information are effective April 1, 2025. Premium deduction changes will occur on your April paycheck(s).

What do I need to do if I want to enroll in a flexible spending account?

Enroll or re-enroll in the pre-taxed Medical and Dependent Care Flexible Spending Accounts in Workday. Remember, **if you do not enroll or re-enroll, you will not have a flexible spending account** in 2025-26.

Willamette University

2025 Open Enrollment Meeting Schedule

Benefits: One-on-One Appointments (Zoom - 30 minutes):

Schedule a benefits one-on-one! Have benefit or open enrollment questions? Please reach out to Benefits Manager, Tiffany DeGroat, to schedule an appointment.

Email: tdegroat@willamette.edu

Scheduled Time Slots:

Date	Time
Monday, February 10, 2025	10:00 AM – 4:00 PM
Wednesday, February 12, 2025	10:00 AM – 2:30 PM
Thursday, February 13, 2025	10:00 AM – 3:30 PM
Friday, February 14, 2025	10:00 AM – 4:00 PM
Tuesday, February 18, 2025	10:00 AM – 3:30 PM
Wednesday, February 19, 2025	10:00 AM – 1:00 PM
Friday, February 21, 2025	10:00 AM – 1:00 PM
Wednesday, February 26, 2025	9:00 AM – 3:00 PM

**Other appointment times are available upon request*

Fidelity Investments: Learning Events including Ask Fidelity Q & A Session:

We are pleased to offer you the opportunity to attend a scheduled online Zoom session with Ronald Elia, our dedicated Retirement & Financial Planning Specialist.

- During the sessions, Ronald will discuss how to make the most of your retirement savings, which will include information on new contributions for 2025. The session will conclude with a brief Q & A.

The scheduled dates and times for these sessions are as follows:

Date	Registration	Time	Event
February 14, 2025	Click here to register	11:30 AM – 12:00 PM	How to Make the most of Your Retirement and Q & A Session
February 21, 2025	Click here to register	11:30 AM – 12:00 PM	How to Make the most of Your Retirement and Q & A Session
February 25, 2025	Click here to register	11:30 AM – 12:00 PM	How to Make the most of Your Retirement and Q & A Session

Fidelity Investments: One-on-One Appointments with a Specialist

Ronald (and other Fidelity Financial Planning Specialists) are also available to meet with you individually to discuss your personal financial planning and answer any specific questions you may have. You can schedule time with Ronald by visiting the following link:

Click here to schedule an appointment (or go to https://digital.fidelity.com/prgw/digital/wos/)

MONTHLY HEALTHCARE RATES 2025 - 26

Employee's Salary: $0-$50,000

Medical- Kaiser HMO				Medical-Added Choice PPO			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$865.41	**$0.00**	$865.41	Employee	$1,325.39	**$459.98**	$865.41
Employee + 1	$1,730.81	**$331.73**	$1,399.08	Employee + 1	$2,650.78	**$1,251.70**	$1,399.08
Family	$2,405.83	**$462.28**	$1,943.56	Family	$3,684.59	**$1,741.03**	$1,943.56

Employee's Salary: $50,001-$100,000

Medical- Kaiser HMO				Medical-Added Choice PPO			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$865.41	**$41.47**	$823.95	Employee	$1,325.39	**$501.44**	$823.95
Employee + 1	$1,730.81	**$414.68**	$1,316.13	Employee + 1	$2,650.78	**$1,334.65**	$1,316.13
Family	$2,405.83	**$576.39**	$1,829.44	Family	$3,684.59	**$1,855.15**	$1,829.44

Employee's Salary: $100,001+

Medical- Kaiser HMO				Medical-Added Choice PPO			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$865.41	**$82.93**	$782.48	Employee	$1,325.39	**$542.91**	$782.48
Employee + 1	$1,730.81	**$497.61**	$1,233.21	Employee + 1	$2,650.78	**$1,417.57**	$1,233.21
Family	$2,405.83	**$691.66**	$1,714.17	Family	$3,684.59	**$1,970.42**	$1,714.17

MONTHLY DENTAL RATES 2025 - 26

Employee's Salary: $0-$50,000

Kaiser (HMO) Dental Plan				The Standard (PPO) Dental Plan			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$61.88	**$0.00**	$61.88	Employee	$52.28	**$0.00**	$52.28
Employee + 1	$123.75	**$43.31**	$80.44	Employee + 1	$104.56	**$36.60**	$67.96
Family	$172.01	**$77.40**	$94.60	Family	$146.36	**$65.86**	$80.50

Employee's Salary: $50,001-$100,000

Kaiser (HMO) Dental Plan				The Standard (PPO) Dental Plan			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$61.88	**$6.18**	$55.70	Employee	$52.28	**$5.34**	$46.94
Employee + 1	$123.75	**$49.50**	$74.25	Employee + 1	$104.56	**$41.82**	$62.74
Family	$172.01	**$82.56**	$89.45	Family	$146.36	**$69.81**	$76.55

Employee's Salary: $100,001+

Kaiser (HMO) Dental Plan				The Standard (PPO) Dental Plan			
	Total	**Employee Pays**	WU Pays		Total	**Employee Pays**	WU Pays
Employee	$61.88	**$9.28**	$52.60	Employee	$52.28	**$7.94**	$44.34
Employee + 1	$123.75	**$61.88**	$61.87	Employee + 1	$104.56	**$52.28**	$52.28
Family	$172.01	**$86.01**	$86.00	Family	$146.36	**$73.18**	$73.18

Healthcare Comparison

Willamette University 2025-26

Plan Name & Provider Network	Option 1: Kaiser Medical HMO	Option 2: Added Choice POS		
		Tier 1	Tier 2	Tier 3
	Kaiser Providers	Kaiser Providers	First Choice PPO Providers	Non-Participating Providers
Calendar Year Deductible**	Individual $500 Family $1,500	Individual $1000 Family $3,000	Individual $2,000 Family $6,000	Individual $3,000 Family $9,000
Calendar Year Out-of-Pocket Maximum** *Tiers 1 & 2 cross accumulate	Individual $3,000 Family $9,000	Individual $4,000* Family $8,000*	Individual $6,000* Family $12,000*	Individual $7,500 Family $15,000
Preventive Care	$0	$0	$0	40% coinsurance after deductible
Primary Care / Naturopathic Care/ Outpatient Mental Health Care	1st 3 visits $5, then $15	1st 3 visits $5, then $25	1st 3 visits $5, then $35	40% coinsurance after deductible
Specialty Care	$25	$35	$45	40% coinsurance after deductible
Urgent Care	$35	$45	$55	40% coinsurance after deductible
Diagnostic Lab & X-Ray	$15 per department visit	$25 per department visit	$35 per department visit	40% coinsurance after deductible
CT, MRI, PET Scan	$100 per department visit	$100 per department visit	30% Coinsurance after deductible	40% coinsurance after deductible
Inpatient Stay/Surgery	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Emergency Room	20% Coinsurance after deductible	$200 after deductible (waived if admitted)		
Ambulance Services	20% Coinsurance after deductible	20% Coinsurance after deductible		
Durable Medical Equipment	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Self-Referred Alternative Care *(Acupuncture, Chiropractic, Massage Therapy)*	$25 per visit. Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	$25 per visit. Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	20% Coinsurance Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	40% coinsurance Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits
Prescription Retail *(Up to 30 – day supply)*	$20 generic $40 preferred $60 non-preferred	$20 generic $40 preferred $60 non-preferred		
Mail Order Prescriptions (Up to 90 – day supply)	$40 generic $80 preferred $120 non-preferred	*Kaiser Mail Order* $40 generic $80 preferred $120 non-preferred	*Med Impact Mail Order* $60 generic $120 preferred $180 non-preferred	
Routine Eye Exam	$15 co-pay	$25 co-pay	$35 co-pay	40% coinsurance after deductible
Vision Hardware and optical services	$250 annual allowance	$250 annual allowance		

****Deductibles, out of pocket maximums, and alternative care visit limits accumulate on a calendar year basis.**

Dental Comparison

Willamette University 2025-2026

Plan Name & Provider Network	**Option 1: Kaiser Dental HMO** Kaiser Providers Only	**Option 2: The Standard Dental PPO** Provider network: Classic Network *(In and out of network coverage available)*
Annual Deductible	None	$0 for preventive care $50 per person per calendar year for other *(limited to 3 deductibles per family)*
Annual Maximum Benefit	$1,500 per person (preventive services do not apply)	$1,500 per person per calendar year
Office Visits	$15 co-pay	None
Preventive Services *Exams, cleanings, x-rays, fluoride treatment*	Fully covered after office visit charge	Employee pays 0% (deductible waived)
Basic Services *Fillings, simple extractions*	Fully covered after office visit charge	Employee pays 20% after deductible is met
Major Services *Crowns, Bridges, Dentures*	Employee pays 20%	Employee pays 50% after deductible is met
Emergency Treatment/ Out-of-Area Treatment (The Standard Only)	Plan pays up to $100 for out-of-area emergency	Employee pays same percentages as above for Preventive/Basic/Major services Non-network provider services are subject to Usual and Customary allowances
Orthodontia *No age limit*	Employee pays 50% $1,500 per claimant lifetime maximum	Employee pays 50% $1,500 per claimant lifetime maximum (deductible waived)
Orthodontia Lifetime Maximum	$1,500	$1,500

Please note: This summary provides a brief description of the Plan benefits. Please refer to the Summary Plan Description for a complete list of benefits, limitations, and exclusions that apply and a definition of medical necessity.

Guardian · uprisehealth

Employee Assistance Program Overview

Our comprehensive Employee Assistance Program (EAP), available through Uprise Health, provides you and your family members with confidential, personal and online/web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

Employee assistance program consultative services

- **Online modules and coaching** — learn, develop, and practice new skills to improve mental fitness; includes a well-being check, online modules selected specifically for you, and up to 3 coaching sessions
- **Face-to-face and virtual counseling** — up to 3 visits per employee/household member per issue, per year
- **Bereavement** — support available through telephonic or face-to-face sessions; online resources available on EAP website
- **EAP website resources** — includes webinars, podcasts, articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP consultant

Work-life assistance and resources

- **Work-life services** — unlimited 24/7 access to work-life specialists (subject matter experts) in the areas of family and care giving, health and wellness, emotional well-being, daily living, and balancing work and life responsibilities
- **Child and elder care referral** — unlimited telephonic consultation with a work-life specialist (part of Work-life services)
- **Employee discounts** — access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Medical billing negotiation tools** — information and guidance on negotiating medical bills

Legal/Financial assistance and resources*

- **Legal consultation** — unlimited telephonic support and free initial 30-minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial consultation** — unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID theft** — free consultation with a trained Fraud Resolution specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- **WillPrep** — online self-service documents available on EAP website; discounted estate planning package options available includes: $100 attorney assisted will package, $179 couples will package, $649 individual trust package, and $999 couples trust package**
- **Tax consultation** — tax questions only can be answered as part of the financial consultation offering
- **Online self-service legal documents** — examples include, but are not limited to, living trust, will, power of attorney, deeds

worklife.uprisehealth.com

Access code: worklife
Phone: 1-800-386-7055
24 hour crisis help available. Regular office hours: Monday-Friday 6am-5pm PST.

Have You Ever...

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Worried about being a victim of identity theft?
- ☐ Been concerned about your child's identity?
- ☐ Had social media accounts? (Facebook, Instagram, Twitter, Linkedin, Youtube)

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** On unlimited personal issues
- **Letters/Calls** Made on your behalf
- **Contracts/Documents Reviewed** Up to 15 pages
- **Residential Loan Document Assistance** For the purchase of your primary residence
- **Will Preparation** - Living Will, Health Care Power of Attorney
- **Speeding Ticket Assistance** Upload your speeding ticket from the mobile app directly to law firm
- **IRS Audit Assistance** (Begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (If named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (Available 90 days after enrollment)
- **25% Preferred Member Discount** (Bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** For covered situations

The IDShield Membership Includes:

- **Credit Monitoring** Continuous credit monitoring through Experian
- **Online Privacy Management** IDShield provides consultation and guidance on ways participants can protect their privacy and personally identifiable information across the internet and on their smart devices.
- **Reputation Management & Score** Scans social media accounts for existing content that could be damaging to participants' online reputation. Ranks your online reputation risk by giving you a score based off the content found on your social media accounts.
- **Financial Account Monitoring** Accounts monitored include checking, savings, employer 401k accounts, loans and more.
- **$3 Million Protection Policy** Coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** Ensures that we won't give up until your identity is restored!
- **Identity Restoration** Performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- **24/7 Emergency Access** In the event of an identity theft emergency

Plan	Family Price	Individual Price
LegalShield	$18.95 Monthly	$18.95 Monthly
IDShield	$18.95 Monthly	$8.95 Monthly
Combined	$33.90 Monthly	$27.90 Monthly

Put your law firm and identity theft protection in the palm of your hand with the LegalShield and IDShield mobile apps!

LegalShield | IDShield

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Workday Open Enrollment Instructions

Introduction

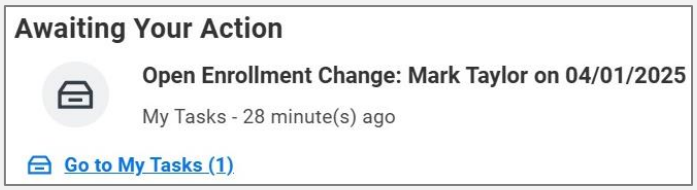
This guide will assist you in making changes to your benefit elections. You will be using the Willamette Workday system to view and make changes to your benefits as desired. Note that if you don't wish to make any changes, no action is necessary, but if you participate in a flexible spending account program you must re-enroll every year.

Step 1: Login to Workday and Initiate Open Enrollment

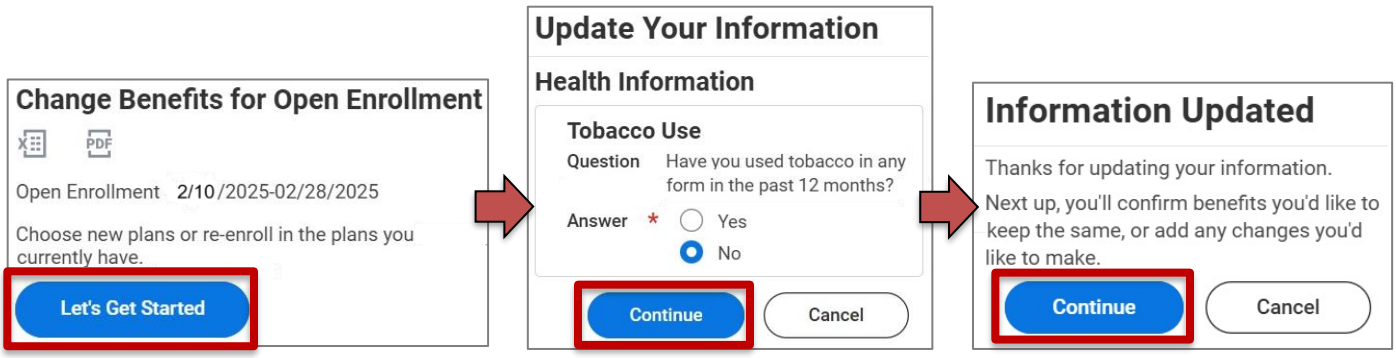
1. Go to workday.willamette.edu.

Enter your login credentials as needed.

Click **Open Enrollment Change** in your Tasks inbox.



2. On the subsequent screens, click **Let's Get Started**, indicate your tobacco use, and click **Continue**.



3. On the following screen, you will be presented with a series of tiles organized into three sections:

- Health Care and Accounts
- Insurance
- Additional Benefits

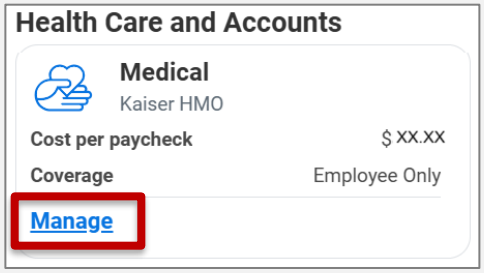
To make changes or enroll in a new plan, click **Manage** or **Enroll** at the bottom of each tile. The following sections will provide you with more detail for working with each benefit.

Step 2: View and Make Changes to Health Care Elections

Medical and Dental Elections

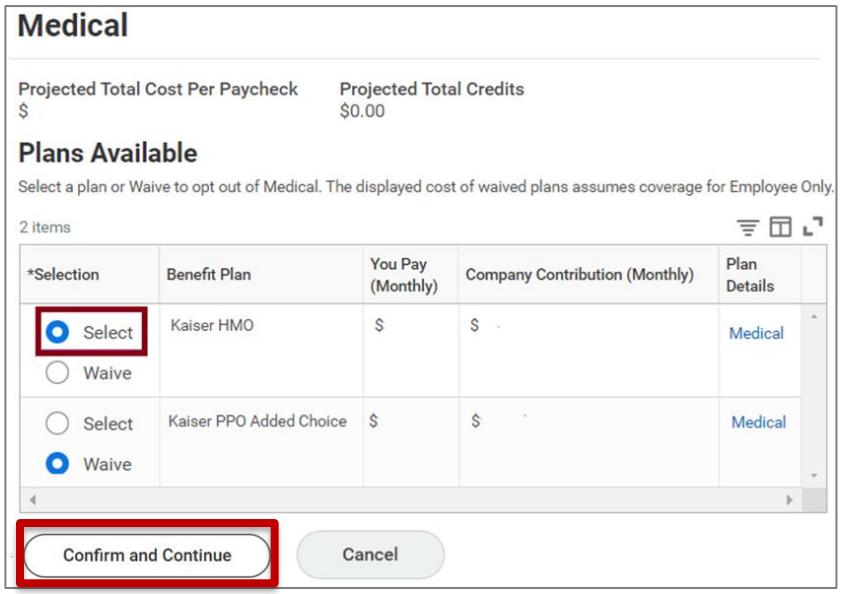
The same method is used to enroll in or make changes to medical and dental plans. We review making changes to medical insurance in this example. More information about the medical and dental plans can be found here.

1. Click **Manage** or **Enroll** at the bottom of the Medical tile.



2. Click the **Select** radio button next to the plan you wish to enroll in. In this example, the Kaiser HMO button is selected.

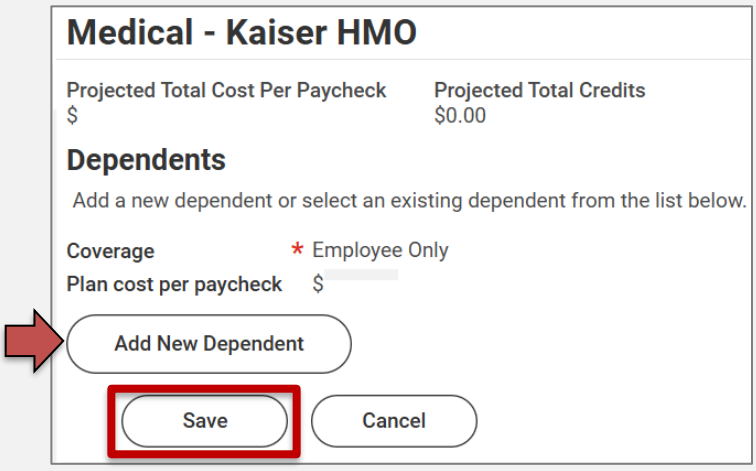
Click **Confirm and Continue**.



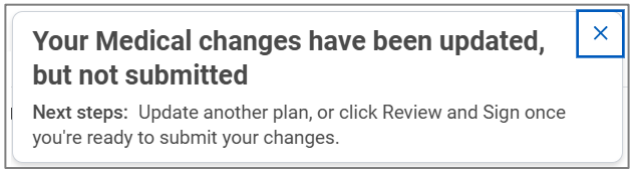
3. Your cost per paycheck for enrolling in the plan will display.

If you wish to add dependents to the plan, click **Add New Dependents** and follow the instructions.

When you are done, click **Save**.



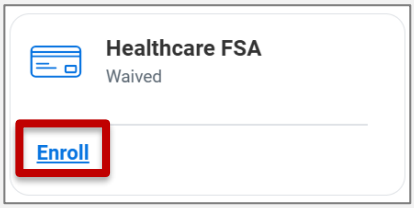
4. You will receive a confirmation that your changes have been updated.



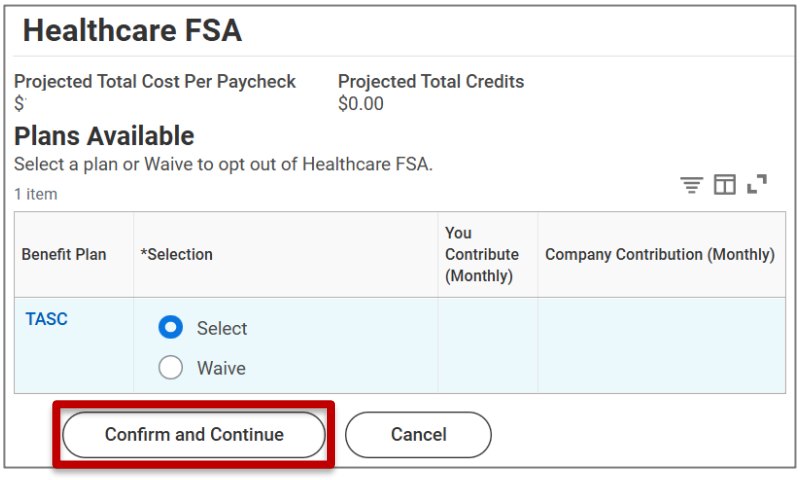
Flexible Spending Account Elections

Willamette offers healthcare, dependent care, and mass transit flexible spending account programs. For more information about these programs, click here. These instructions demonstrate enrollment in the Healthcare Flexible Spending account, but the same process is used for Dependent Care enrollment. The Mass Transit Flex can be joined at any time during the year and is therefore not included in Open Enrollment.

1. Locate the Healthcare FSA tile and click **Enroll**.

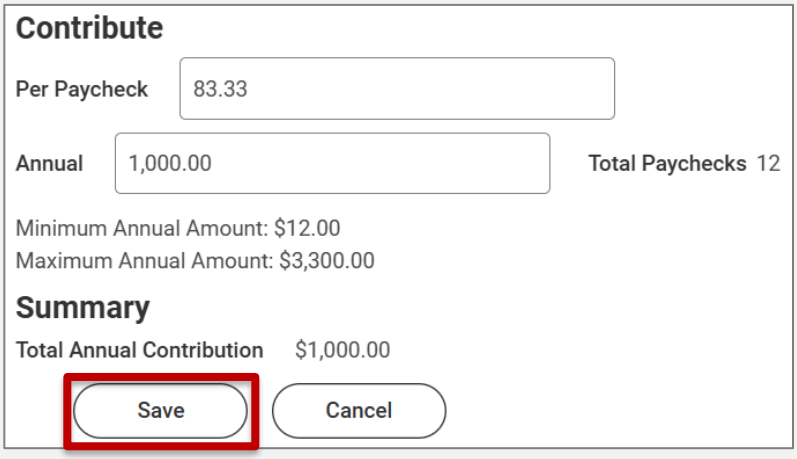


2. On the following screen, click the **Select** radio button and then the **Confirm and Continue** button.

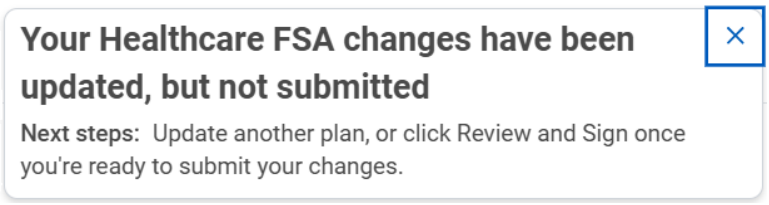


3. You may enter either a per paycheck amount or the annual amount you wish to contribute. Entering either input area will populate the other and provide a total annual contribution. In this example, $1,000 was entered as the annual amount.

Click **Save** after your selection is made.



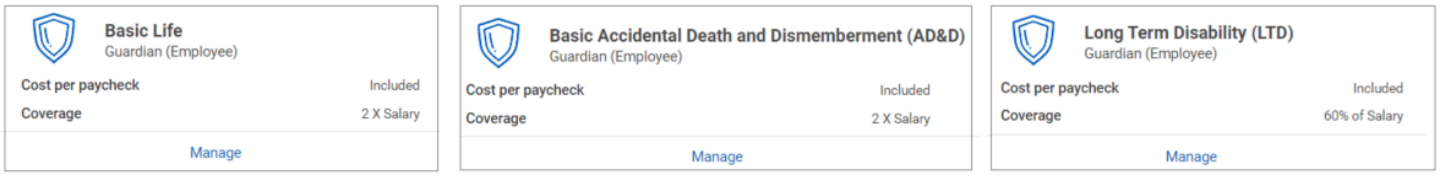
4. When finished you will receive a confirmation of your choice.



Step 3: Insurance and Retirement Elections

Willamette Sponsored Benefits

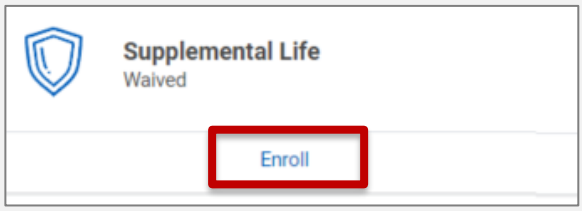
Willamette provides Basic Life, Accidental Death & Dismemberment (AD&D) Insurance, and Long-Term Disability benefits at no cost to employees working 75% of a full-time schedule (30 hours a week). These plans are automatically populated with your plan information. You may view, but not make changes to these plans. For more information, click here.



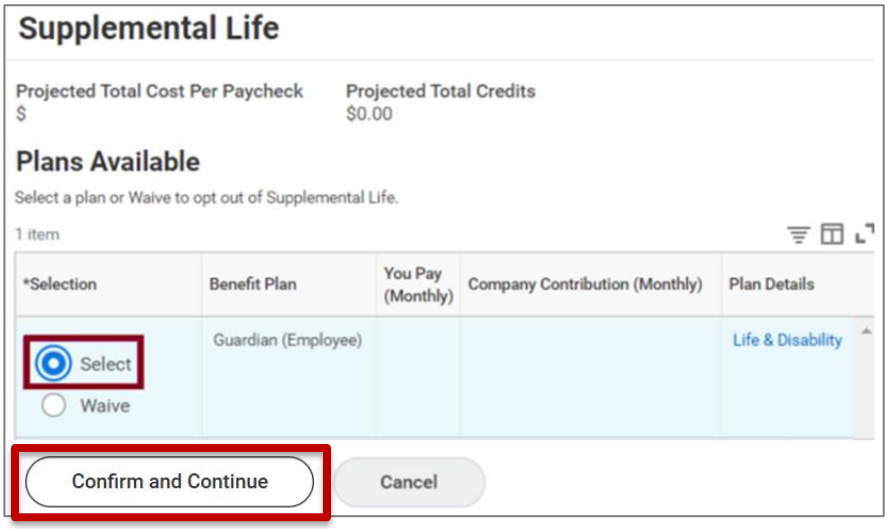
Voluntary Supplemental Life and AD&D Insurance

In addition to the insurance provided by Willamette, you may elect to add additional Life and AD&D insurance for yourself and your family. The directions below show how to add Supplemental Life and AD&D Insurance for yourself, but the same directions apply to adding these benefits for your spouse and children. Note that your spouse's amount of insurance elected cannot be higher than the amount you have chosen for yourself, and that higher amounts of coverage may be subject to providing Evidence of Insurability. To review these and other plan rules, click here.

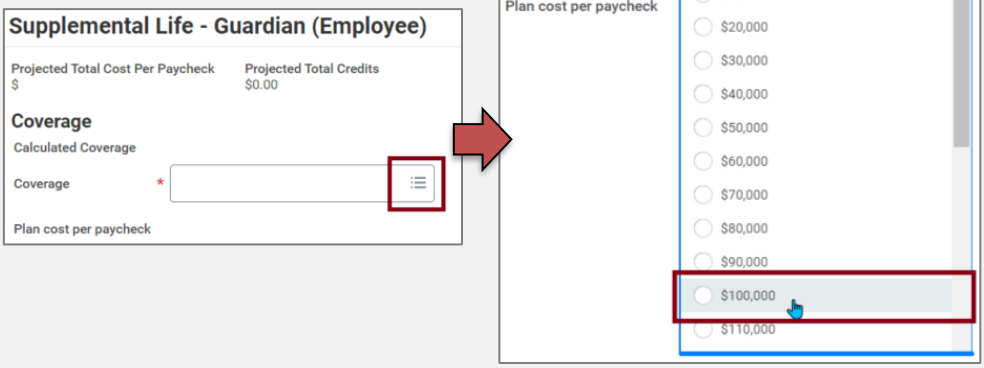
1. Click **Manage** or **Enroll** on the Supplementary Life tile.



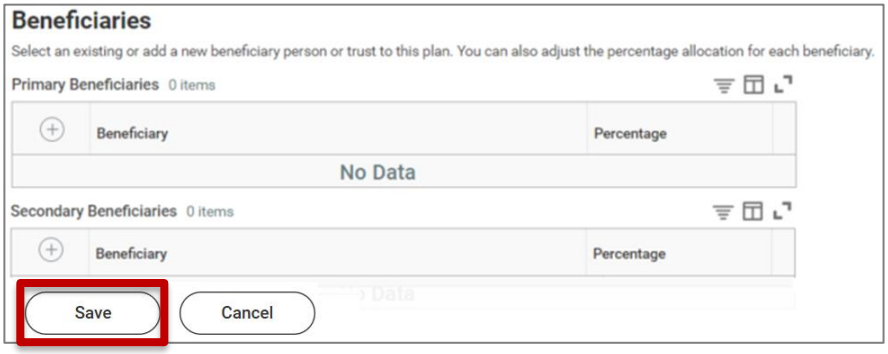
2. Click the **Select** button and then **Confirm and Continue**.



3. Click the list icon on the right-hand side of the Coverage box. A list of coverage amounts will appear. Select the amount of coverage you wish to elect. In this example, $100,000 is chosen.

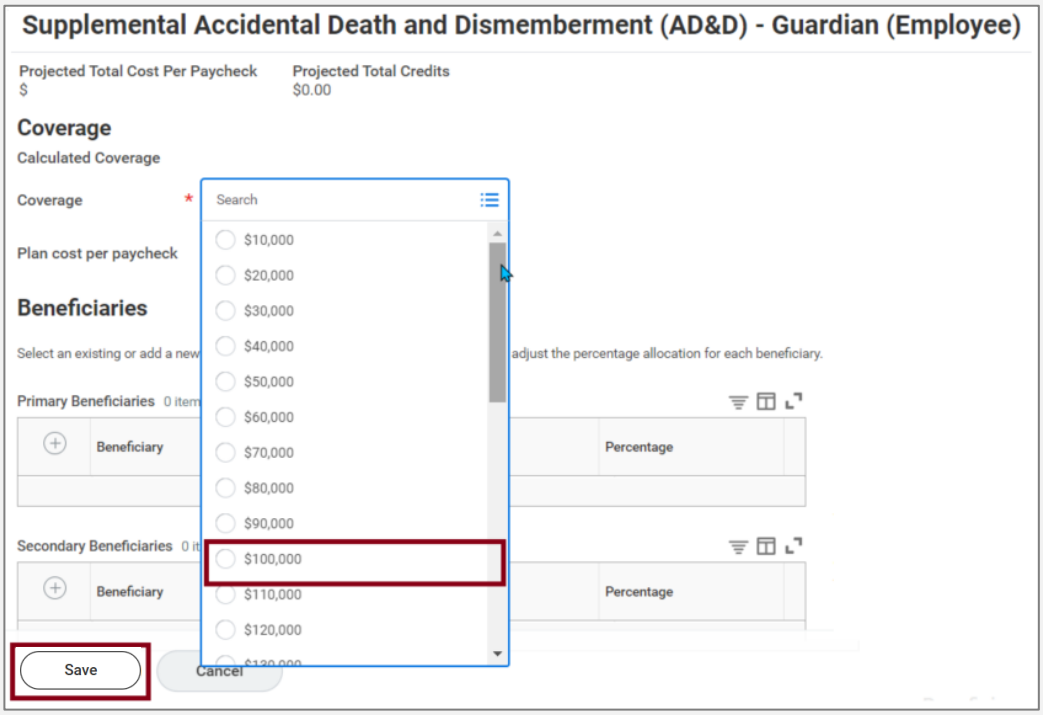


4. If you have not entered beneficiaries for this benefit, do so in the following section. You can find detailed directions for adding beneficiaries later in this booklet. When done, click **Save** and you will receive a confirmation message that your changes were successful.



5. The Supplemental Life and AD&D Insurance are bundled, so it will also be necessary to add Supplemental AD&D. The process is the same as adding Supplemental Life.

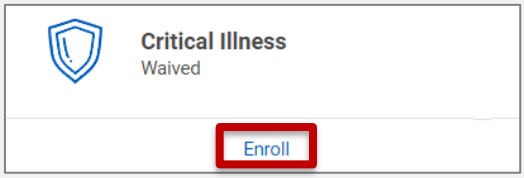
- Click **Manage** or **Enroll** on the Supplemental Life tile.
- Select the coverage amount desired from the drop down list.
- Add beneficiaries as needed.
- Click **Save**.



Critical Illness

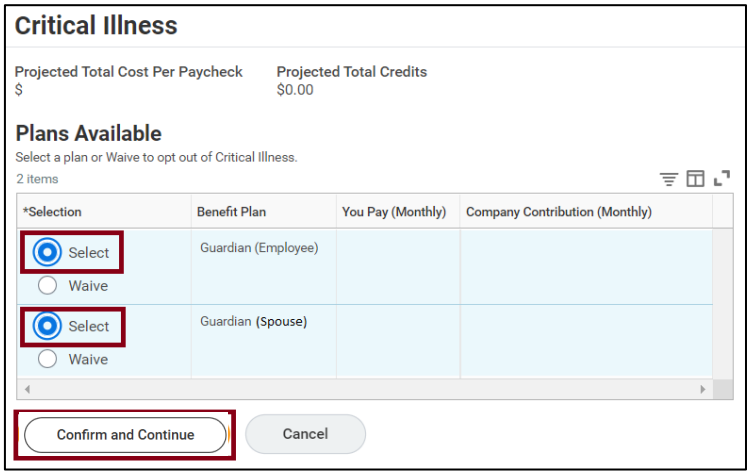
Critical Illness Insurance can help with expenses that medical insurance doesn't cover like deductibles or out of pocket costs, or services like experimental treatment. To find more information about this benefit, click here, and scroll down to Guardian Accident and Critical Illness section. The process for signing up for Critical Illness is similar to Supplemental Life Insurance.

1. Click **Enroll** to join the benefit or **Manage** to make changes.

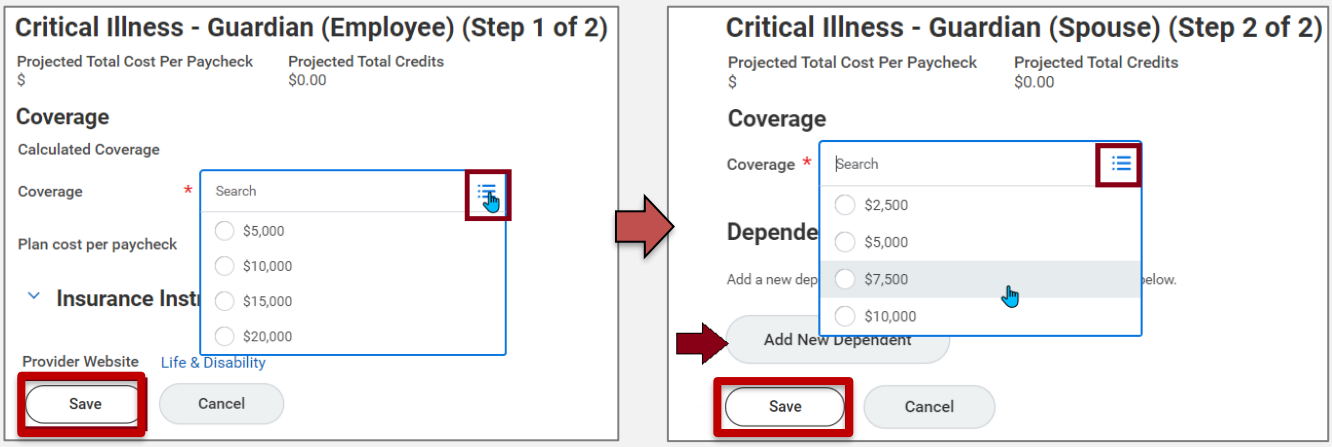


2. Click **Select** for each level of benefit you wish to elect. In this example, both employee and spouse are selected.

Click **Confirm and Continue** when done.



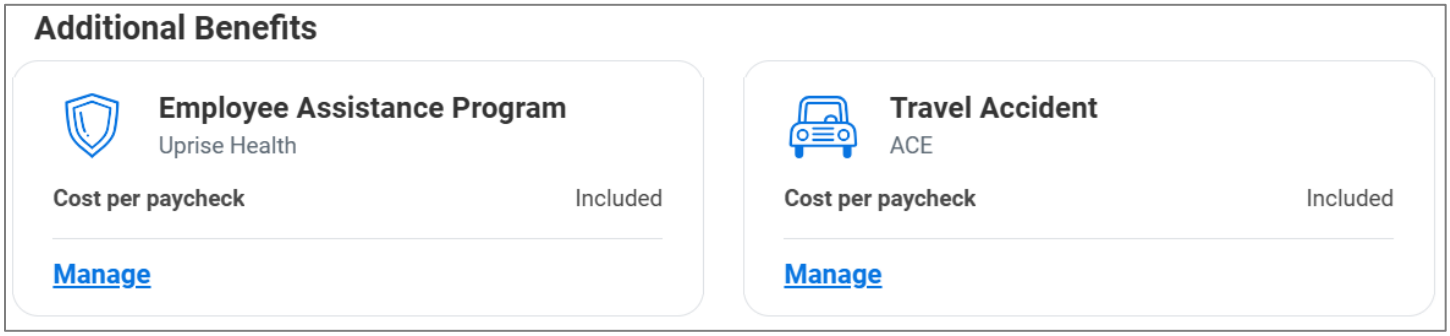
3. On the following screen, select the amount of coverage for yourself by clicking the menu icon in the Coverage field, selecting the amount, and then clicking **Save**. Repeat selecting a coverage amount for your spouse, clicking the **Add New Dependent** button to add your spouse, and then clicking **Save.**



4. You will receive the standard confirmation pop-up window indicating you have finished.

Step 4: Additional Benefits

Willamette Sponsored Benefits



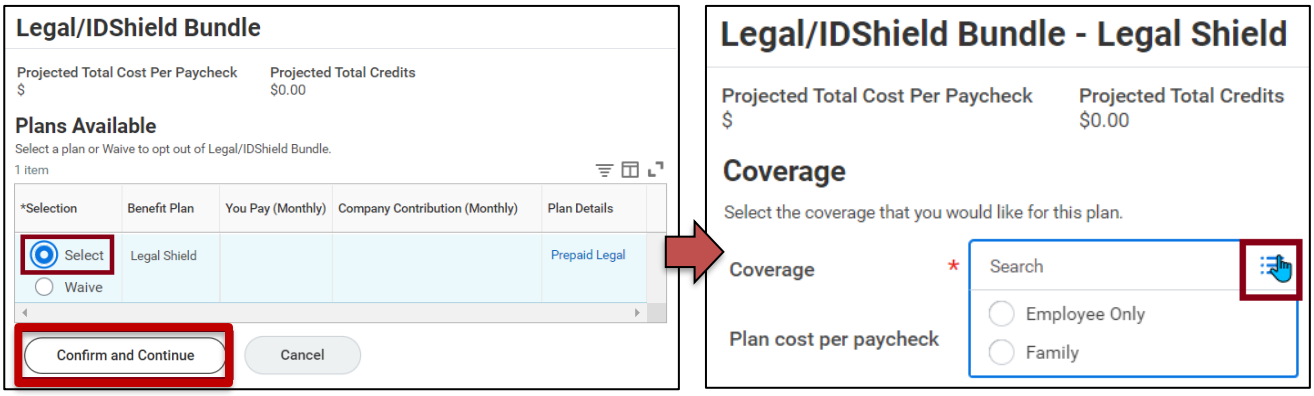
Willamette provides an Employee Assistance Program (EAP) and Travel Accident Insurance to employees at no cost. These plans are automatically populated with your plan information. You may view, but not make changes to these plans. For more information about the EAP, click here and scroll down to Employee Assistance Program. You may also find out more information about the ACE Travel Accident program here.

Legal Shield/ID Shield

Legal Shield and ID Shield provide additional personal protection with legal and financial concerns as well as identity theft protection. You can opt to join one or the other or choose to have them bundled together. These instructions show you how to join the bundled program. For more information about these benefits, click here, then scroll down to Legal Services and Identity Theft.

1. Click **Enroll** in the Legal/ID Shield Bundle tile.

2. Click **Select** and then **Confirm and Continue**. On the following screen, select whether you are covering yourself only or if you wish to cover yourself and your family.

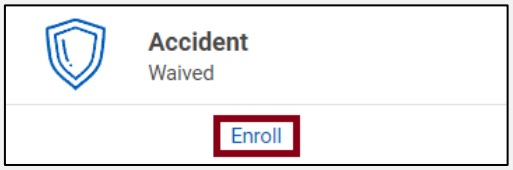


3. When done, click the **Save** button, and you will receive a confirmation message.

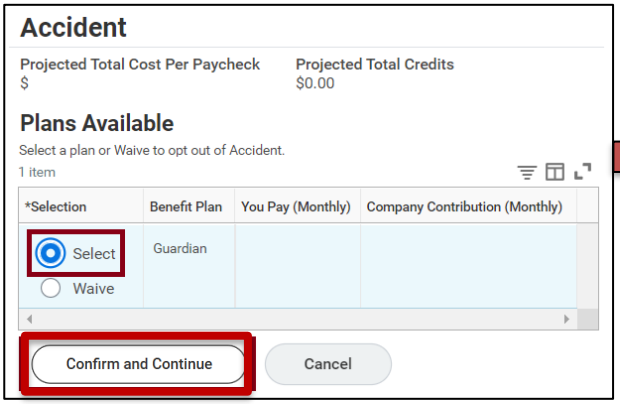
Accident Insurance

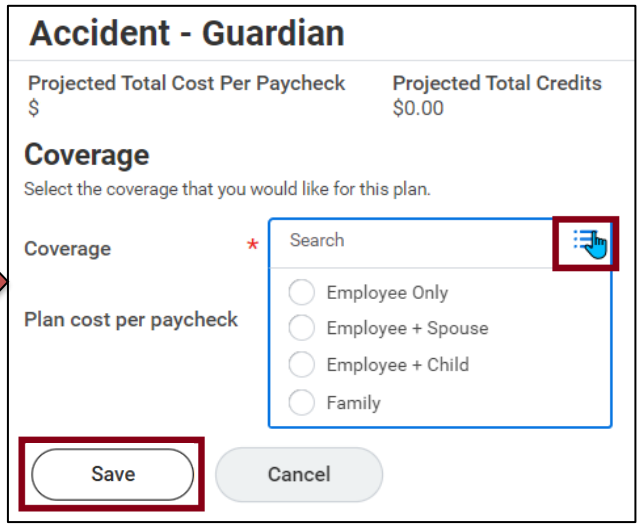
Accident Insurance can help you with your medical deductibles and co-pays, and cover household expenses like groceries, mortgage payments, and childcare, which can begin to pile up if you have to take some time off from work due to an accident. For more information about this benefit, click here.

1. Click **Enroll** in the Accident tile.



2. Click **Select**, then click **Confirm and Continue**. On the following screen, click the menu button in the coverage field and select the level of coverage from the drop-down menu. Click **Save**.





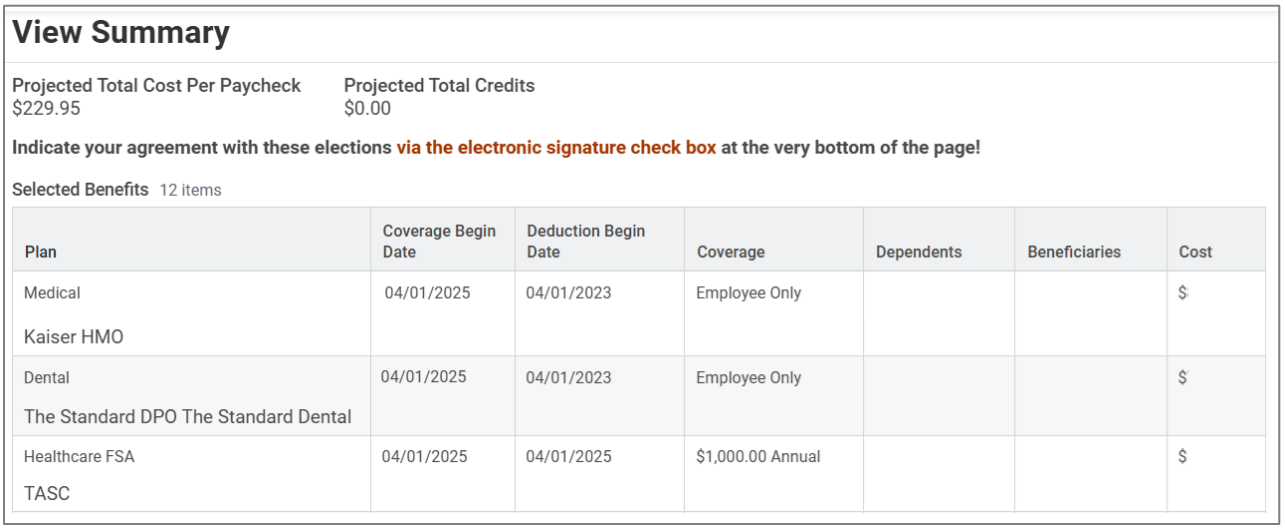
3. You will receive a confirmation message indicating you are done.

You are almost done! Go to the next page to see how to finalize your Open Enrollment elections.

Step 5: Finalize Benefit Selections

1. Once you made your benefit selections, go to the bottom of the screen that displays the benefit tiles. If you are ready to finalize your selections, click **Review and Sign**. If you wish to stop and come back later to complete your benefit elections, click **Save for Later**. This will create a reminder task in your Workday inbox to complete the process.

2. After clicking **Review and Sign**, you will be presented with the total cost of your benefits, the plans you have selected, and coverage details associated with each plan.



View Summary

Projected Total Cost Per Paycheck
$229.95

Projected Total Credits
$0.00

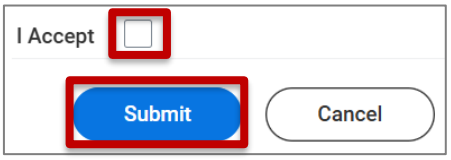
Indicate your agreement with these elections via the electronic signature check box at the very bottom of the page!

Selected Benefits 12 items

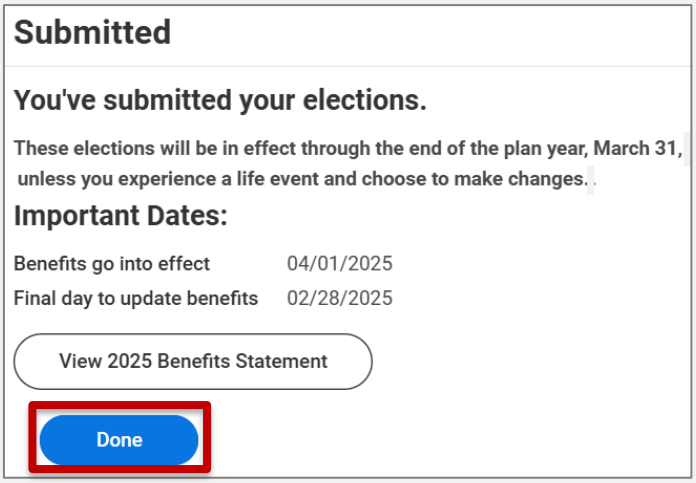
Plan	Coverage Begin Date	Deduction Begin Date	Coverage	Dependents	Beneficiaries	Cost
Medical Kaiser HMO	04/01/2025	04/01/2023	Employee Only			$
Dental The Standard DPO The Standard Dental	04/01/2025	04/01/2023	Employee Only			$
Healthcare FSA TASC	04/01/2025	04/01/2025	$1,000.00 Annual			$

3. After the summary of your current elections, you will see a section showing which benefits you have waived, messages regarding any further action needed, and a summary of your total cost share.

4. If you are satisfied with your elections and are ready to complete your Open Enrollment, scroll down to the **I Accept** checkbox and select the box after reading through the Electronic Signature message. Click the **Submit** button.



5. You will receive a confirmation of submission message. Click **Done** to complete the open enrollment process.



Submitted

You've submitted your elections.

These elections will be in effect through the end of the plan year, March 31, unless you experience a life event and choose to make changes.

Important Dates:

Benefits go into effect 04/01/2025

Final day to update benefits 02/28/2025

View 2025 Benefits Statement

Done

We are happy to answer your questions. Please contact us at (503) 370-6210 or hr@willamette.edu. Have a great Open Enrollment!

Key Contact Information

The following table provides important phone numbers and websites that you may need when enrolling for your benefits and throughout the year.

Options	Website	Group #	Phone Number
Enrollment Portal Online			
[ ]Workday	workday.willamette.edu	N/A	N/A
Health Insurance			
[ ] Added Choice Medical Plan	http://willamette.edu/offices/hr/benefits/healthcare_coverage/index.html	02014	1-866-616-0047
[ ] Kaiser Medical Plan		02014	1-800-813-2000
Dental Insurance			
[ ] The Standard Dental Plan	http://willamette.edu/offices/hr/benefits/healthcare_coverage/index.html	160-762267	1-800-547-9515
[ ] Kaiser Dental Plan		02014	1-800-813-2000
Life Insurance - Guardian			
[ ] Optional Group Term Life and AD&D (Buy-up)	http://willamette.edu/offices/hr/benefits/insurance_plans/index.html	00510968	1-888-600-1600
Flexible Spending Account - TASC			
[ ] Health Care [ ] Dependent Care [ ] Mass Transit	http://willamette.edu/offices/hr/benefits/spending_account_plans/index.html	4907-2738-1332	1-800-422-4661
Retirement Plans - Fidelity			
[ ] Voluntary Contributions	http://willamette.edu/offices/hr/benefits/retirement/voluntary.html	92040	1-800-343-0860
Accident - Guardian			
[ ] Accident Lump Sum [ ] Critical Illness with Cancer	http://willamette.edu/offices/hr/benefits/additional_benefit_plans/index.html	00510968	1-888-600-1600
Legal Services and Identity Theft – LegalShield			
[ ] Legal Plan [ ] Identity Theft	http://willamette.edu/offices/hr/benefits/additional_benefit_plans/index.html	willametteuniversity	1-800-654-7757

Still have questions? We are happy to help you:

Human Resources
(503) 370-6210
hr@willamette.edu

WILLAMETTE UNIVERSITY

Annual Legal Notices for Employee Benefits Participants

MEDICARE PART D NOTICE

Medical Plan: Kaiser Foundation Health Plan of the Northwest

About Your Prescription Drug Coverage and Medicare

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 join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined the prescription drug coverage offered by Kaiser Foundation Health Plan of the Northwest is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage...

Contact the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

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

For more information about Medicare prescription drug coverage: Visit www.Medicare.gov or 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 800-MEDICARE (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. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call (800) 772-1213 (TTY 1-800-325-0778).
Remember to keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.
HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.
The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.
PHI refers to individually identifiable health information received by the company's group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.
All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.
The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.
Company records that are governed by this policy will be maintained for a period of no less than six years.
Questions or issues regarding PHI should be addressed with Human Resources.
You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.
You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

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

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with

childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE

Health plans through Kaiser Foundation Health Plan of the Northwest will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through Kaiser Foundation Health Plan of the Northwest:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

PATIENT PROTECTION

Kaiser Foundation Health Plan of the Northwest generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. To designate your primary care provider contact Kaiser Foundation Health Plan of the Northwest at (800) 813-2000

Until you designate a primary care provider, Kaiser Foundation Health Plan of the Northwest may designate one for you. For children, you may have the ability to designate a pediatrician as the primary care provider as defined in component plan documents.

You may not need prior authorization from Kaiser Foundation Health Plan of the Northwest or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. See Component Plan Documents for details.

FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a dependent child.

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

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), or the commencement of a proceeding in bankruptcy with respect to the Company, the employee must notify the Plan Administrator of the qualifying event.

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), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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, Medicaid, 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

Emergency services

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

OREGON COMPREHENSIVE PROTECTIONS AVAILABLE:

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides a payment standard*
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities
    - enrollees who consent to non-emergency out-of-network services**
    - enrollees of self-funded plans

Notes:

* Oregon determines reimbursement rates for anesthesia and non-anesthesia claims according to two separate payment formulas. Generally speaking, these rates are based on allowed claims data for commercial carriers from 2015 as obtained from the Oregon APCD, which are then adjusted for a variety of factors including geographic region, changes to the enrollee price index, and complexity of service.

** Protections do not apply when enrollee "chooses" to receive services, which means all of the following conditions have to be met:

- enrollee had a reasonable alternative;
- enrollee was informed of the reasonable alternative;
- enrollee was informed of the out-of-pockets cost of the out-of-network service;
- enrollee provided informed consent; and
- consent is documented.

Referenced from https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

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

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

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

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

OREGON COMPREHENSIVE PROTECTIONS AVAILABLE:

State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing

- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides a payment standard*
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities
    - enrollees who consent to non-emergency out-of-network services**
    - enrollees of self-funded plans

Notes:
* Oregon determines reimbursement rates for anesthesia and non-anesthesia claims according to two separate payment formulas. Generally speaking, these rates are based on allowed claims data for commercial carriers from 2015 as obtained from the Oregon APCD, which are then adjusted for a variety of factors including geographic region, changes to the enrollee price index, and complexity of service.
** Protections do not apply when enrollee "chooses" to receive services, which means all of the following conditions have to be met:
- enrollee had a reasonable alternative;
- enrollee was informed of the reasonable alternative;
- enrollee was informed of the out-of-pockets cost of the out-of-network service;
- enrollee provided informed consent; and
- consent is documented.
Referenced from https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 the federal phone number for information and complaints.
Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.
Visit https://dfr.oregon.gov/news/2018/Pages/20180301-balance-billing.aspx for more information about your rights under Oregon.

Annual Legal Notices for Employee Benefits Non-Participants

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.

The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.

PHI refers to individually identifiable health information received by the company’s group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.

The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.

Company records that are governed by this policy will be maintained for a period of no less than six years.

Questions or issues regarding PHI should be addressed with Human Resources.
You may request a copy of the current Privacy Practices from the Plan
Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.
You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone

assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

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

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.
If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.
If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

With the key parts of the health care law that took effect in 2014, there is a new way to buy health insurance: **the Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by Willamette University.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The Open Enrollment period each year is usually between the beginning of November to mid-January; this can sometimes vary by state. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you may not be eligible for a tax credit through the Marketplace depending on the below factors and your household income. You may want to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the 2024 year, or if the coverage your employer provides does not meet the "minimum value"* standard set by the Affordable Care Act, you may be eligible for a tax credit. Beginning in 2021 with the American Rescue Plan Act (ARPA), and extended for tax years 2023-2026 by the Inflation Reduction Act of 2022, the federal poverty ceiling is no longer capped at 100%-400%, and the applicable percentage of household income to qualify for a tax credit through the marketplace has been lowered to 8.5 %.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. Residents of the following states must use the state-run health exchange, and more information about the state-specific sites can be found at https://www.healthcare.gov/marketplace-in-your-state/

CA, CO, CT, DC, ID, KY, MA, MD, ME, MN, NJ, NM, NV, NY, PA, RI, VT, WA

Information About Health Coverage Offered by Your Employer

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

1. Employer Name: Willamette University
2. Employer Identification Number (EIN): 93-0386972
3. Employer Address: 900 State St
4. Employer phone number: (503) 370-6631
5. City: Salem
6. State: OR
7. ZIP code: 97301

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

• As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Regular full-time employees working an average of 30 hours or more per week on an annual basis.

• With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: Spouse or domestic partner and their eligible children.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. if you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

WILLAMETTE UNIVERSITY

Important-Time Sensitive

Open Enrollment Information

2025