Benefits Enrollment Guide

2025 Plan Year

Point
UNIVERSITY

Hospital Indemnity Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Table of Contents

This guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.

Medicare Part D Notice (pages 24-25)

Contact Information

Medical

EBMS
Medical Customer Service: 1-866-462-9054
Claims: P.O. Box 21367 Billings, MT 59104
EDI# 81039
RX (VeracityRx): 1-888-388-8228

Dental and Vision

Renaissance
Dental/Vision Customer Service: 800-894-4532
Website: www.renaissancebenefits.com

Basic Life, Voluntary Life, AD&D, Long and Short Term Disability

Prudential
Customer Service and Claims: 1-800-842-1718
Website: www.prudential.com

FSA

AmeriComp Benefits, Inc.
Phone Number: 706-327-6511 or 1-800-868-0196
Fax Number: 706-327-1160
Email: support@americompbenefits.com
Address: AmeriComp Benefits, Inc.
PO Box 4319, Columbus, GA 31914

Telemedicine

SwiftMD
Phone Number: 833.794-3863

401(k)

Empower
Phone Number: 800-338-4015
Website: www.empowermyretirement.com

Guidance Resources

Prudential
Phone Number: 1-800-311-4327
www.guidanceresources.com

Voluntary Benefits

Aflac
Phone Number: 706-315-8047
Email Address: douglas_crawfordjr@us.aflac.com

If You are a New Employee

If you are a new employee, you and your eligible family members can participate in the Point University benefit package on the first day of the month following 30 days of employment. Just keep in mind that if you are a new employee who is disabled and away from work on the date that your coverage would become effective, you'll have to wait until you return to work before your coverage goes into effect. If a family member is confined in a hospital or confined to the house because of an illness or injury, they would also have to wait for coverage to begin.

About Payroll Deductions

Equal payroll deductions will be taken from each paycheck. Keep in mind that your Medical, Dental, Vision, and Flexible Spending premiums will be deducted on a pre-tax basis because they are covered under Section 125. This means that once you elect to enroll in this plan, you will not be allowed to drop or change your election until the following annual enrollment, unless you have a Qualifying Life Event.

Annual Enrollment

Annual Enrollment is the only time during the year that gives you the opportunity to review your benefits selections and make changes if needed. In addition, if you are eligible and not currently enrolled, you may enroll in the benefits at this time.

Steps to Enroll in UKG

To enroll or update your benefits, navigate to Point's Single Sign On portal (my.point.edu). Select the UKG button to log in. Click the Menu icon and choose My Benefits. Select Enrollment. Choose the "Start Open Enrollment", "Start New Employee Enrollment" or "Life Change Event" button on the menu. Contact the HR Department if you have any questions regarding this process or your benefits.

Dependent Eligibility

You must remove a dependent from coverage once they no longer meet the definition of an eligible dependent listed below.

Eligible dependents include:

- Spouse (not to include domestic partners)
- Dependent children up to age 26; coverage will end on the end of the month following 26th birthday
- Dependent children beyond age 26 incapable of self-support due to mental or physical handicap

Please refer to the Summary Plan Description for more information regarding dependent eligibility.

Qualifying Life Events

Benefit plan changes are permitted if you have a Qualifying Life Event. A Qualifying Life Event is an event defined by the IRS in Section 125 that allows you to change your benefit selections. Qualifying Life Events include:

- Birth or adoption of a child.
- Marriage, Divorce or Legal Separation.
- Death of a spouse or child.
- Spouse's change in insurance eligibility due to gain/loss of employment.
- Change in your employment status (full-time to part-time).
- Dependent loses or gains insurance eligibility.

You must contact Human Resources and provide the necessary documentation within 30 days of the change. **If you do not do so within 30 days, you must wait until the next Annual Enrollment to make benefit plan changes.**

Important Note Regarding Medical Premiums:

If you are covering a spouse on your Point University medical plan, you are required to participate in the open enrollment each year and answer the spousal surcharge question. This year, your acceptance or waiver for the spouse surcharge will ONLY be collected online. You must go online to indicate whether or not the surcharge applies to you.

If your spouse is eligible for coverage under another group health plan, and you enroll him or her in one of the medical plans sponsored by Point University, there will be an additional surcharge of **$1,800 annually/ $69.23 bi-weekly.**

By submitting your election online, you attest that the information provided is true and correct to the best of your knowledge. An employee who provides false information, or conceals for purpose of misleading information concerning and fact material thereto, may be subject to disciplinary action up to and including termination of employment.

Medical Buy-Up Plan Plan Summary of Benefits

Benefit Features	Buy-Up Plan In-Network
Calendar Year Deductible (Individual/Family)	$500/$1,500
Coinsurance	Member pays 10%
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximum (Individual/Family)	$4,400/$13,200
Office Visit Copays	
Primary Care Physician	$25
Specialist	$50
Urgent Care	$60
Maternity Services *(prenatal, delivery, postpartum)*	1st Prenatal Visit - $25 copay; then Member pays 10% after deductible
Mental Health Counseling *(Up to 26 visits per year)*	$25 Primary Care; $50 Specialist
Preventive Care	
Well child care, Immunizations	Plan pays 100%
Periodic health exams	Plan pays 100%
Annual gynecology exams	Plan pays 100%
Prostate screenings	Plan pays 100%
Emergency Room Copay *(waived if admitted)*	$150 copay; then Member pays 10%
Hospital Services	
Inpatient	Member pays 10% after deductible
Outpatient	Member pays 10% after deductible
Therapy Services	
Speech Therapy	$25 *(20-visit max per calendar year)*
Physical/Occupational Therapy *(combined)*	$25 *(20-visit max per calendar year)*
Chiropractic Care	$25 *(20-visit max per calendar year)*
Respiratory Therapy	Member pays 10% after deductible
Radiation and Chemotherapy	Member pays 10% after deductible
Prescription Drugs	
Retail *(30-day supply)*	
Tier 1a/Tier 1b/Tier 2/Tier 3	$15/$30/$35/$60
Tier 4	20% up to $300 max per prescription

Medical Bi-Weekly Payroll Deductions	
Medical Options:	**Buy-Up Plan**
Employee	$102.65
Employee + Spouse	$221.04
Employee + Child(ren)	$182.74
Family	$296.96

Medical Base Plan Plan Summary of Benefits

Benefit Features	Base Plan In-Network
Calendar Year Deductible (Individual/Family)	$2,000/$6,000
Coinsurance	Member pays 0%
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximum (Individual/Family)	$6,600/$13,200
Office Visit Copays	
Primary Care Physician	$25
Specialist	$50
Urgent Care	$60
Maternity Services *(prenatal, delivery, postpartum)*	1st Prenatal Visit - $25 copay; then Member pays 0% after deductible
Mental Health Counseling *(Up to 26 visits per year)*	$25 Primary Care; $50 Specialist
Preventive Care	
Well child care, Immunizations	Plan pays 100%
Periodic health exams	Plan pays 100%
Annual gynecology exams	Plan pays 100%
Prostate screenings	Plan pays 100%
Emergency Room Copay *(waived if admitted)*	$150 copay
Hospital Services	
Inpatient	Member pays 0% after deductible
Outpatient	Member pays 0% after deductible
Therapy Services	
Speech Therapy	$25 *(20-visit max per calendar year)*
Physical/Occupational Therapy *(combined)*	$25 *(20-visit max per calendar year)*
Chiropractic Care	$25 *(20-visit max per calendar year)*
Respiratory Therapy	Member pays 0% after deductible
Radiation and Chemotherapy	Member pays 0% after deductible
Prescription Drugs	
Rx Deductible	$200 per member (Tier 2 & 3 only)
Retail *(30-day supply)*	
Tier 1a/Tier 1b/Tier 2/Tier 3	$15/$30/$40/$75
Tier 4	20% up to $300 max per prescription

Medical Bi-Weekly Payroll Deductions	
Medical Options:	**Base Plan**
Employee	$35.05
Employee + Spouse	$70.10
Employee + Child(ren)	$60.28
Family	$108.22

The Balance Billing Cycle

Don’t break the bank,. Let us break the cycle.

You work hard for your money. The last thing you want to do is pay a medical bill without knowing if you are overpaying. As your health plan’s partner, ELAP Services (ELAP) reviews medical claims for potential errors and to make sure charges don’t exceed your plan’s limits.

What you Need to Know: Most providers will accept a fair payment from your plan. However, some providers may send you a bill for the difference between what your plan paid and the amount they charged.

If that happens, ELAP is here to help!

YOUR PART: Identity Balance Bills

Compare the eOB and the Provider Bill

After receiving medical care, keep an eye out for the Explanation of Benefits (EOB) from your health plan and a Provider Bill sent by the doctor or facility.
Compare the “amount you owe” on the EOB and bill. If they don’t match, this is a balance bill.
ELAP will help!

Send Bill to ELAP

Send any balance bills you receive to ELAP right away so we can get to work!
You can rely on us to address any billing issues with the provider.

OUR PART: Advocate on Your Behalf

Pay Confidently with ELAP’s Support

Once we have your written permission, ELAP will work to resolve the bill with the provider on your behalf. We will:

- Assign a dedicated Member Services Advocate to support you and provide regular updates
- Arrange for comprehensive legal support at no extra cost, if necessary
- Provide access to live and online support

Send your balance bill to ELAP. It’s easy!

Email a clear snapshot from your phone or computer to:
bb@elapservices.com

Fax a copy:
1-888-560-2447

Mail a copy:
1550 Liverty Ridge Drive
Suite 330, Wayne, PA 19087

QUESTIONS? We’re here for you.
Phone: 1-800-977-7381 | **Email:** bb@elapservices.com

Preventive Care (EBMS)

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life. Our health plans offer the services listed in this preventive care flier at no cost to you.[1] **When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket.** You may have to pay part of the costs if you use a doctor outside the network.

Preventive Versus Diagnostic Care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child Preventive Care

Preventive Physical Exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's Preventive Care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

Preventive Care (EBMS)

Adult Preventive Care

Preventive Physical Exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[6]
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

A Word About Pharmacy Items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 6-12 months

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides[5,7]
- Folic acid for women 55 years old or younger
- Vitamin D for women over 65
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)[6]

Lab Card

Welcome to Quest Diagnostics Lab Card Program!

Lab Card is part of your health benefit plan. This is a consumer-driven benefit that allows you to obtain outpatient laboratory testing services at no cost to you*. When you direct your testing under Quest Diagnostics Lab Card Program to a participating laboratory, and the testing is covered and approved by your health benefit plan —you pay no deductibles, no copays and no coinsurance.* It's up to you to request to use Quest Diagnostics Lab Card Program.

Common Questions About the Lab Card Program

Q. What is Lab Card?

A. Lab Card is a voluntary program that allows you to obtain 100% coverage for outpatient laboratory testing*. When your doctor requires laboratory testing, you can avoid copays and/or deductibles by asking to use your Lab Card Program. The testing must be covered and approved by your health benefit plan and your physician or phlebotomist must indicate that you have the Lab Card Program on a Quest Diagnostics requisition which accompanies your specimens to Quest Diagnostics.

Q. Is use of Lab Card mandatory?

A. No. This is a voluntary, consumer-driven program. However, if you choose not to use Lab Card, your normal benefits will apply.

Q. Does Lab Card replace current healthcare benefits?

A. No. It simply provides you the option to receive covered outpatient laboratory testing at no out-of-pocket cost to you* when you present your Lab Card and ask for the Lab Card Program.

Q. Who pays for the laboratory testing when I use Lab Card?

A. Your health benefit plan. Under the Lab Card Program you receive 100% coverage for covered laboratory tests.

Q. What tests are covered under Lab Card?

A. The program covers diagnostic outpatient laboratory testing provided the tests have been ordered by your physician, are covered and approved by your health benefit plan and you have requested to use your Lab Card Program. Outpatient lab work includes:

- Blood testing (e.g., cholesterol, CBC).
- Urine testing (e.g., urinalysis).
- Cytology and pathology (e.g., pap smears, biopsies).
- Cultures (e.g., throat culture).

How to Use Your Lab Card

1. At your physician's office or a Lab Card collection site, show your healthcare card with the Quest Diagnostics and/or Lab Card logo and/or your separate Lab Card and verbally request to use the Lab Card Program. Lab Card is optional, if you do not use Quest Diagnostics Lab Card Program, your regular benefits will apply.
2. If your physician collects Lab Card specimens in their office, they can continue to do so. After the collection is complete, your physician must clearly mark Lab Card on the paperwork and call 1-800-646-7788 to request a Lab Card pick up.
3. If your physician does not collect specimens in his/her office, you may find an approved collection site at www.LabCard.com or by calling 1-800-646-7788. Site information, including locations, Lab Card hours and any special instructions are updated daily, so please visit the website or call 1-800-646-7788 before any visit.
4. **You Save!**

For More Information
Call 1-800-646-7788
or Visit www.LabCard.com

Q. What tests are NOT covered under Lab Card?

A. Lab Card does not cover all lab work, including:

- Lab work ordered during hospitalization.
- Lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests.
- Nonlaboratory work such as mammography, x-ray, imaging and dental work.
- Lab work performed without the use of your Lab Card benefit.
- Testing that is not approved and/or covered by your current health benefit plan.

Q. Is there a charge for specimen collection?

A. When your specimen is collected at the physician's office, your health benefit plan is billed the physician charges for this service. Provider collection and handling fees may apply, and are subject to health benefit plan provisions.

Q. What if my physician doesn't collect specimens?

A. Most of the time, the physician or physician office staff collects your specimen(s) and calls Lab Card Client Services for pickup. If the physician is unable to collect the specimens, check the website at www.LabCard.com or call 1-800-646-7788 to see if there is an approved collection site in the area. Please verify hours of collection for the Lab Card Program and collection site capabilities, specifically glucose tolerance testing and pediatric draws.

If a collection site that meets your needs is available, you can take a completed test order or Quest Diagnostics requisition from your physician outlining the tests to be performed to the collection site. You should show your Lab Card to the office staff and verbally request to use your Lab Card Program. The testing must be covered and approved by your health benefit plan and your physician or phlebotomist must indicate that you have Lab Card on the paperwork that accompanies your specimens. Specimens will be collected by a trained medical professional and sent to the laboratory for testing. Results will be sent to your physician, generally the next day. If you do not use your Lab Card Program, you will continue to receive lab services as you always have—normal benefits will apply.

Q. What if a physician does not collect specimens for the Lab Card Program, wants to perform the testing in his or her own office, or have the specimens sent to a laboratory of his/her choice?

A. You may have lab work performed at another laboratory without using the Lab Card Program; however, your normal benefits will apply — you will be responsible for your standard deductibles, coinsurance and copays.

Q. What if the physician or the office staff has not heard of Lab Card?

A. Ask them to call Lab Card Client Services at 1-800-646-7788 to speak with a client service representative who will explain the Lab Card Program and fax a packet of information for their immediate use. You can also call the Lab Card Client Services number or visit the website, www.LabCard.com, to ask that they contact your physician in advance of your next visit.

Q. What if I receive a bill for lab work?

A. If you receive a bill from Quest Diagnostics after receiving an explanation of benefits or denial for services from your health benefit plan, and you disagree with the denial, contact your health benefit plan for assistance. If the denial of services is due to lack of health benefit plan coverage, you will be responsible for payment. If you have questions about whether or not specific testing is covered, please consult your health benefit plan.

Q. Can testing under the Lab Card Program be sent to any Quest Diagnostics laboratory?

A. Yes. To ensure you receive the benefit of the Lab Card Program, you must show your healthcare card with the Lab Card logo and/or Lab Card and verbally request to use the Lab Card Program. Your physician should clearly mark Lab Card on your laboratory orders and call 1-800-646-7788 for a Lab Card pick up. Or, visit our website: www.LabCard.com to locate an approved collection facility, which will collect your specimen, send it to an approved Quest Diagnostics laboratory and the results will be sent back to your physician, typically the next day.

**Provider collection and handling fees may apply, and are subject to health benefit plan provisions.*

If you have additional questions about Lab Card, call 1-800-646-7788.

Dear Participating Member,

We are pleased to provide the Lab Card® Program with your health benefit plan. The Lab Card Program offers you and your eligible dependents outpatient laboratory testing at no cost* when your testing is sent under the Lab Card Program to a participating Quest Diagnostics laboratory. To use this voluntary program, the testing must also be ordered by your physician, covered and approved by your health benefit plan.

Using the Lab Card Program is Simple

You must show your healthcare card/Lab Card with the Lab Card logo at your physician's office or a contracted collection site and verbally request to use the Lab Card Program. There are two ways to use the Lab Card Program:

Collection at Your Physician's Office

- Your physician can collect your specimens in the office and call 1-800-646-7788 for a pickup. Please note, if your doctor charges a specimen collection fee, your health benefit plan will be billed for this service. (The specimen collection fee will be applied to your benefits based on plan provisions and you may be responsible for payment of this fee.)
- A courier will pick up the specimens at the physician's office and send them to a participating Quest Diagnostics laboratory for testing. Results will be sent to your physician, typically the next day. If specimens are sent to a laboratory other than Quest Diagnostics, you will be responsible for deductibles, coinsurance and copays.

Collection at a Lab Card Collection Site

- If your physician is unable to collect your specimens, he or she can write a test order for you to take to a Lab Card collection site.
- To locate an approved collection site in the area, you can call Lab Card Client Services at 1-800-646-7788 or visit www.LabCard.com. Be sure to call or check the website prior to any visit as collection site information, including locations, hours of collection, capabilities, and special instructions, is updated daily.
- Your specimens will be sent to a participating Quest Diagnostics laboratory and results will be sent to your physician, typically the next day.

The Lab Card Program applies to diagnostic outpatient laboratory testing, which includes blood testing, urine testing, cytology and pathology, and cultures. The Lab Card Program does not apply to lab work ordered during inpatient hospitalization; lab work needed on an emergency (STAT) basis, and time-sensitive, specialized outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests; nonlaboratory work such as mammography, x-ray, imaging and dental work; lab work performed by another lab; and testing that is not approved and/or covered by your health benefit plan.

The Lab Card Program helps control healthcare costs and provides members with an opportunity to save on covered outpatient laboratory testing. If you have any questions, please call Lab Card Client Services at 1-800-646-7788 .

Dental (Renaissance)

About the Dental Plan

Dental Benefits are available to you and your eligible family members to cover routine care such as exams, x-rays and cleanings, as well as fillings, dentures, bridge work and periodontal care. Under the Renaissance plan, you can go to the dentist or provider of your choice and receive the same level of benefits, however out of network providers may bill you for charges that exceed the usual, reasonable and customary rates that Renaissance will allow. Utilize the www.renaissancebenefits.com website to locate network providers near you.

Dental Summary of Benefits		
PPO Network	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 Individual / $150 Family	
Preventive Services Routine Exams Routine Cleanings Fluoride Bitewing X-rays Space Maintainers Sealants	100%	100%
Basic Services Full Mouth X-Rays, Fillings, Stainless Steel Crowns	80%	80%
Major Services General Anesthesia, Oral Surgery, Periodontics, Endodontics, Bridges, Dentures, Crowns, Inlays/Onlays	50%	50%
Orthodontic Services *(Adults and Children)*	50%	50%
Annual Maximum	$1,000 per person	
Lifetime Orthodontic Maximum	$1,000 per person	
Note: Deductible is waived for Preventive Services.		

Dental Bi-Weekly Payroll Deductions	
Employee	$4.86
Employee + Spouse	$15.36
Employee + Child(ren)	$22.84
Family	$35.48

Vision (Renaissance)

Vision benefits are available to you and your eligible dependents to cover lenses, frames, contacts and routine care such as exams. **The VSP Network** is nationwide including private practice and retail providers. To obtain a list of in-network vision care providers, go to www.renaissancebenefits.com or call 1-800-894-4532.

Vision Bi-Weekly Payroll Deductions	
Employee	$2.94
Employee + Spouse	$5.13
Employee + Child(ren)	$5.58
Family	$7.77

Vision Plan Summary of Benefits		
	In-Network	**Out-of-Network**
Exam	Plan pays 100% after $20 copay	
Materials	Plan pays 100% after $20 copay	
Frequency *(Exams/Lenses/Frames)*	12/12/24 (months)	
Lenses		
Single Vision	Covered in Full	$25
Bifocal Vision	Covered in Full	$40
Trifocal Vision	Covered in Full	$55
Frames	$150 Allowance	$45
Contact Lenses		
Conventional	$150 Allowance	$105
Medically necessary	Covered in full	$210
Standard Contact Fitting	Up to $55	Discounts not available
Premium Contact Lens Fitting	10% off retail price	Discounts not available

Please note: Members are only able to select glasses OR contacts each year. The plan will only cover one or the other on an annual basis. For example, if you wear glasses and contacts, you can use your vision plan to cover lenses and frames, and the plan will not cover contacts for that year. You would be able to use your Flexible Spending Account to pay for contact lenses.

Basic Life and AD&D (Prudential)

Point University automatically provides Basic Life and Accidental Death and Dismemberment (AD&D) coverage to full-time employees in the amount of $20,000 at **no cost to the employee**. The benefit will double when death is the result of an accident.

The Life Insurance also provides what is commonly referred to as an **Accelerated Life Benefit**. This means if you are diagnosed with a terminal illness with a documented life expectancy of less than 12 months, you may collect 75 percent up to $250,000 of your life insurance prior to your death. This money can be used for any type of expenses.

The Life policy also provides **Waiver of Premium**. This means if an insured becomes Totally Disabled before reaching age 60 and is not able to work for at least six consecutive months, the insured can then apply for a waiver of premium. This waiver would cease at age 65.

Your Basic Life and AD&D coverage will reduce to:

- 65% upon attainment of age 65
- 50% upon attainment of age 70
- Benefits will terminate upon retirement.

Voluntary Term Life (Prudential)

Voluntary Life Insurance provides the opportunity to supplement benefits provided by Point University. You may consider purchasing additional life insurance at favorable group rates. At the time of initial enrollment eligibility, associates can enroll in the Voluntary Life plan up to the Guarantee Issue amounts without evidence of good health.

If you leave employment with Point University, you will have the option to continue your coverage by either converting it into an individual whole life policy or porting it into an individual term life policy with Prudential. Pricing and rates are determined by Prudential.

You may purchase additional Life Insurance for your eligible dependents. Please note:

- You must elect coverage on yourself in order to elect coverage for dependents
- If your spouse works for Point University, you cannot be covered as an employee and a dependent
- Dependent children may only be covered as a dependent under one parent

If you choose to purchase Voluntary Term Life insurance after your initial eligibility period, you must complete an evidence of insurability (EOI) form and be approved by the insurance carrier underwriters. Any volume increases for yourself, your spouse, or your dependent children will require an EOI.

The following charts outline the enrollment criteria and rates for the Voluntary Life Insurance policies. The cost of the life insurance will also be provided when you call or go online to complete your enrollment.

Your Voluntary Life Insurance coverage will reduce to:

- 65% upon attainment of age 65
- 50% upon attainment of age 70

Voluntary Life Insurance Summary of Benefits	
Employee	
Guarantee Issue Amount	$200,000
Benefit Amount	$10,000 increments
Benefit Maximum	$500,000 or 5x annual earnings
Spouse	
Guarantee Issue Amount	$50,000
Benefit Amount	$5,000 increments
Benefit Maximum	100% of Employee election or $250,000
Child(ren)	
Guarantee Issue Amount	$10,000
Benefit Amount	$5,000 increments
Benefit Maximum	100% of Employee election or $10,000

Employee/Spouse Voluntary Life Monthly Rates per $1,000 of coverage			
Age	**Rate**	**Age**	**Rate**
Under 29	$0.05	**50-54**	$0.28
30-34	$0.05	**55-59**	$0.46
35-39	$0.07	**60-64**	$0.66
40-44	$0.12	**65-69**	$1.15
45-49	$0.18	**Over 70**	$2.54

Note: Spouse's rates are based on the employee's age.

Child(ren) Voluntary Life Rates
$0.20 per $1,000 per unit *(per unit is regardless of the number of children)*

Disability (Prudential)

Voluntary Short Term Disability

Short Term Disability (STD) is a weekly benefit paid to replace a portion of your income for a relatively short period of time in the event that you are disabled and unable to work.

Employees must meet a 15-day elimination period prior to receiving a benefit under the Short Term Disability policy. As an example, the industry standard for maternity leave is six weeks for natural birth. If the insured was deemed disabled for six weeks by a physician, she would not receive any benefits for the first two weeks of disability under this policy. After two weeks, the insured would receive 60% of her weekly earnings for the remaining four weeks, or until she is able to return to work.

STD Summary of Benefits	
Benefit Amount	60% of weekly earnings
Maximum Weekly Benefits	$1,000
Maximum Benefit Period	11 weeks
Benefits Begin	15th day
**Pre-existing condition limitations apply.*	

Long Term Disability

Point University will provide Long Term Disability (LTD) to all full-time employees. Below you will find a schedule of benefits for Long Term Disability.

LTD Summary of Benefits	
Benefit Amount	60% of monthly payroll
Maximum Monthly Benefits	$6,000
Maximum Benefit Period	Age 65
Benefits Begin	91st day of disability

ADEA – 65 Reducing Benefit Duration (RBD)	
Age When Disability Begins	Maximum Benefit Period
Less than age 62	To age 65, but no less than 42 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

How to Calculate Short Term Disability Rates

To calculate your STD premium use the following formula. Please use your appropriate age banded rate in the chart below to determine your personal voluntary STD rate.

_____ Annual Salary	×	0.60 (Benefit %)	=	_____ Annual Benefit
_____ Annual Benefit	÷	52	=	_____ Weekly Benefit
_____ Weekly Benefit	÷	10	=	_____ Multiple of Rate
_____ Multiple of Rate	×	Your monthly rate based on your age (see chart)	=	_____ Monthly Premium Cost
_____ Monthly Premium Cost	×	12	=	_____ Annual Premium Cost
_____ Annual Premium Cost	÷	26	=	_____ Bi-Weekly Payroll Deduction Amount

Voluntary Short Term Disability Age Band Monthly Rate (per $10)	
Under 25	$0.47
25-29	$0.48
30-34	$0.46
35-39	$0.40
40-44	$0.44
45-49	$0.44
50-54	$0.52
55-59	$0.55
60-64	$0.60
65-69	$0.69
Over 69	$1.13

Disabilities caused by a pre-existing condition are not covered under the STD plan until you have been insured for 12 months. A "pre-existing" condition is a medical condition for which you received treatment, sought medical care, or took prescribed drugs during the three months prior to becoming insured. In other words, if you sought or received treatment for a medical condition during the three-month period prior to your effective date of coverage, you will not be covered for a disability related to that condition for the first 12 months after your effective date.

Flexible Spending Accounts (AmeriComp Benefits, Inc.)

Flexible Spending Accounts (FSAs) help you save money on eligible healthcare and dependent care expenses by allowing you to pay for those expenses with pre-tax dollars. This reduces your reported taxable earnings by the amounts you contribute to your healthcare and/or dependent care reimbursement accounts.

If you currently participate in a flexible spending account, you must re-enroll for the 2025 plan year.

At the beginning of each plan year, you decide how much (if any) to contribute to each account. Then, each pay period, money is deducted from your paycheck, before taxes are withheld which reduces your income for tax purposes, and placed in the accounts you have specified. When you incur eligible expenses, you simply submit a claim for reimbursement or use your swipe card at the time of service.

There are two separate accounts: a healthcare account and a dependent care account. You may participate in one account, both, or neither.

Healthcare Account

Monies contributed to the Healthcare Account have a $640 rollover feature. If you have funds remaining in your Healthcare Account at the end of the plan year (December 31, 2025), then you will be able to rollover up to $640 into the next plan year without being penalized. Any remaining amounts in the Healthcare Account over $640 will be forfeited at the end of the plan year.

The Healthcare Account allows you to set aside money, before-tax, to pay for anticipated healthcare expenses.

Eligible expenses include:

- Physical Exams
- Deductibles
- Copayments
- Prescription Drugs
- Exams and X-rays
- Orthodontics
- Crowns and Bridges
- Dentures
- Vision Care Exams
- Eyeglasses & Contacts
- Psychiatric Counseling
- Chiropractic Treatment
- Acupuncture Treatment
- And much, much more

Call 1-800-868-0196 or fax 706-327-1160. To obtain a full list of covered expenses, visit http://americompbenefits.com.

FSA Feature: The Swipe Card

You will be issued a swipe card to use when you visit the physician's office or the pharmacy. You use it just like you would a credit card – up to the amount you have elected to have taken out of your paycheck. However, you will need to save all receipts in case you are asked to produce a copy. No more hassle of having to write a check or wondering if you have enough cash.

Dependent Care Account

Point University has adopted the "grace period" amendment which allows funds to be spent after the end of the plan year (December 31, 2025). You have a 2.5 month extension at the end of the plan year to incur eligible Dependent Care expenses before forfeiting any unused funds.

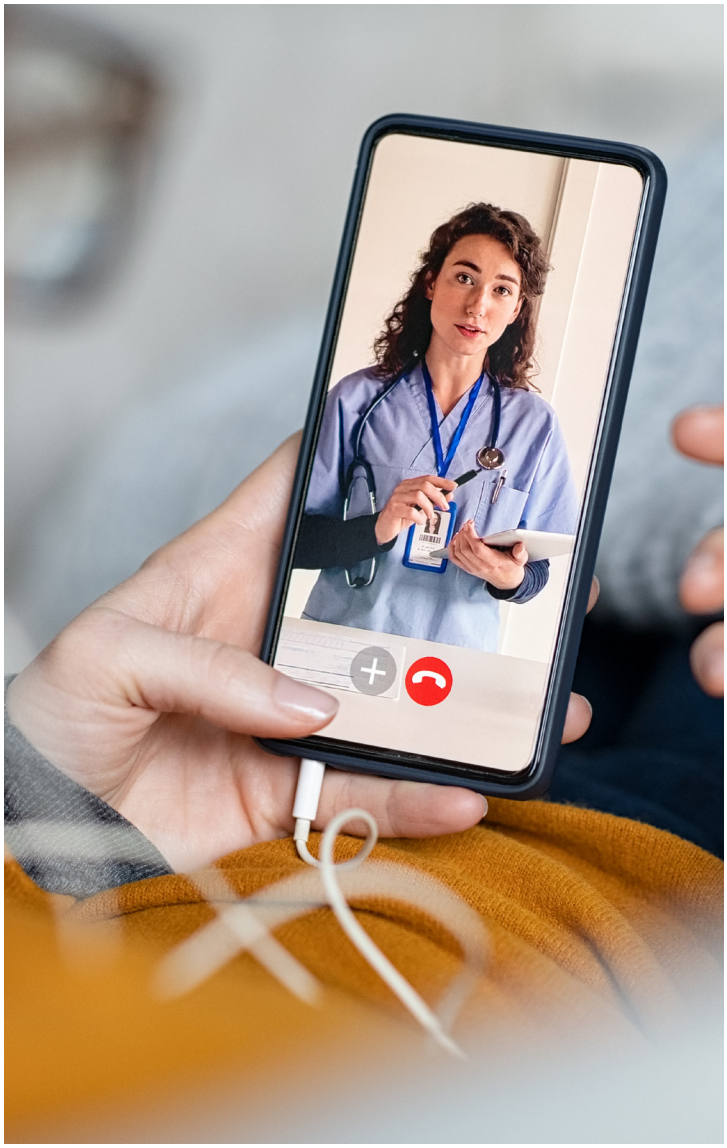
- Final date to incur Dependent Care expenses: December 31, 2025
- Final date to submit claims for reimbursement: March 31, 2026

The Dependent Care Account allows you to set aside money, before-taxes, for eligible dependent care expenses. In general, eligible dependent care expenses include day care for children under the age of 13 who need nursery, pre-school or after-school care, as well as care for any disabled dependent of any age, such as an elderly parent. To qualify as a dependent, the family member must live with you at least 50 percent of the time and be declared a dependent on your income tax return.

More specifically, eligible expenses can include:

- Babysitter inside or outside your home
- Child care or adult care centers that comply with state and local regulations
- Housekeeper whose duties include dependent care
- Person who cares for an elderly or incapacitated dependent
- Relative who cares for your dependents, as long as that relative is not claimed as a dependent on your income tax return

The maximum amount you can set aside in the Healthcare Account is **$3,300** per plan year. The maximum amount you can set aside in the Dependent Care Account is **$5,000** per plan year if you are single or married filing a joint return, and $2,500 per parent if you are married and file separate tax returns.



Questions? Concerns?
Help getting started?

SwiftMD.com
833-SWIFTMD
(833-794-3863)

Conditions We Treat

Telemedicine is appropriate for many common medical conditions, including:

- Allergies and rashes
- Arthritis pain
- Back pain or injury
- Bone or joint pain, strain or injury
- Cold sores
- Diarrhea
- Earache
- Conjunctivitis or pink eye
- Fever and flu
- Headache
- Insect bites and stings
- Lice
- Lyme disease
- Nasal or respiratory congestion
- Sinusitis
- Soft tissue and muscle injuries or pain
- Sore throat
- Stomach ache and nausea
- Upper respiratory infections
- Urinary tract infections
- Vomiting
- Your individual concerns

SWIFTMD
Talk to a doctor 24/7!

401(k) Plan

401(k) Plan Summary of Benefits	
Eligibility	Active Full-time Employees
Enter Plan	At the beginning of the month following 1 month of service.
Contributions	Compensation is all gross W-2 earnings before deferrals. The minimum deferral is 1% of compensation, the maximum deferral is 80%. You can defer up to $18,000 of compensation. For employees who are 50 years of age or older, the law allows a catch-up provision of an additional $7,500 if the deferral limits as stated are met.
Matching Contributions	Point University matches 150% of the first 2% of pay deferred each pay period.
Vesting	Employee Deferrals and the matching contributions are 100% vested at all times.
Change Amount of Deferral	Changes can be made at any time via the Empower website.
Plan Re-Entry	As of the first day of any quarter.
Change Investments	Exchange orders submitted before 4 p.m. will be traded the next business day. Subject to Slavic's trading policy as posted on website.
Reporting	Statements are sent to your home on a quarterly basis. Weekly update of account balance and brief market review is available via the Email Express feature. Daily Valuation is available from the website.
Loan Provision	Up to 50% of the vested amount in participant's account. Minimum $1,000 - Maximum $50,000. Repayment schedule - 5-year amortization pay back schedule, 15-year amortization pay back schedule for primary home loans 4 to 6 week processing time.
Distributions	Distributions can be made out of the plan: at retirement or age 59 ½, in the event of long-term disability, or upon termination of employment from your work site. Hardship withdrawals can be made after the loan provision has been utilized if one of the following criteria is met: to avoid eviction or foreclosure, purchase of primary home, qualifying medical expenses, and payment of tuition or related education fees for the next 12 months of post-secondary education for you, your spouse or your children. These withdrawals are subject to tax and penalties and documentation. Distributions may take up to 30 days from receipt of original paperwork to process.
Retirement Age	The plan document recognizes 65 years of age. Participants may take distributions of their vested account balance at age 59 ½.
Information & Questions	**Phone:** 800-338-4015 **Web Site:** www.empowermyretirement.com

Point University is also offering a Roth retirement savings option. The match remains the same as the above, and you may select to participate in the 401(k), Roth, or both.

GuidanceResources®

An Overview of Your GuidanceResources® Program

No matter what's going on in your life, GuidanceResources® is here to help.

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges. This flyer explains how GuidanceResources can help you.

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A GuidanceConsultant℠ is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Legal Information, Resources and Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

Online Information, Tools and Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com. Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheetsSM on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

WE ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.

Call: 800.311.4327
TDD: 800.697.0353
Online: guidanceresources.com
Your company Web ID: GEN311

Let Aflac help you focus on your priorities

To enroll in any of the Aflac voluntary products, please reach out to Doug Crawford at 706-315-8047 or douglas_crawfordjr@us.aflac.com.

Plan Options Include:

- Accident
- Cancer/Specified Disease
- Critical Illness
- Hospital Indemnity

Employee Benefit Assistants You Can Count On

Marsh McLennan Agency provides you and your family members a complimentary member claims service to help with claims, billing, missing ID cards and more!

Give Member Claims Advocate a call if:

- You received a provider bill or EOB but do not feel the claim was processed correctly.
- You are at the doctor or pharmacy and having trouble with your coverage.
- You need to confirm if a provider is In-Network.
- You are missing your ID card.

You can reach the Member Claims Advocate team by phone or email.

Monday through Friday, 8:15 AM EST – 5:15 PM EST
Email: mmajslbenefitclaims@marshmma.com
Toll Free: (800) 226-4518

General Notice of COBRA Continuation Coverage Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

General Notice of COBRA Continuation Coverage Rights

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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. To update your address, please contact Human Resources.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with Point University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Point University's prescription drug plan is considered Creditable Coverage. 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. Point University has determined that the prescription drug coverage offered by EBMS is 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. You can keep your current coverage from EBMS; however, because your coverage is Creditable, you have decisions to make about Medicare Prescription Drug Coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

When can I join a Medicare drug plan? You can join a Medicare drug plan when you first become eligible for Medicare. The Annual Open Enrollment Period (AEP) is October 15, 2013 to December 7, 2013. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to my current coverage if you decide to join a Medicare drug plan? If you decide to join a Medicare drug plan, your current Point University coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage**), which outlines the prescription drug plan provisions/options that 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 drop your current Point University coverage, be aware that you and your dependents can re-enroll at a later date.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

When will I pay a higher premium (penalty) to join a Medicare drug plan? You should also know that if you drop or lose your current coverage with Point University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. This is called the Late Enrollment Penalty (LEP). If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent 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 November or December to join.

For more information about this notice or your current prescription drug coverage: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Point University changes. You also may request a copy of this notice at any time.

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

For information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Important Notices About Medical Coverage

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 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. To obtain the contact information for your state-sponsored Medicaid or CHIP program, visit http://www.dol.gov/ebsa/compliance_assistance.html.

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):

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

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

Summary Plan Descriptions (SPD)

As required under the Employee Retirement Income Security Act (ERISA), all employees and their covered dependents must be given access to a copy of the Summary Plan Description (SPD) for the employee welfare benefit plans. The SPD outlines the eligibility, schedule of benefits and covered/excluded items of the benefit plans offered by Point University. To obtain a copy of your SPD, contact your Human Resources Department.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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).

Women's Health and Cancer Rights Act Notice

Under the Women's Health and Cancer Rights Act of 1998, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

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

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

Summary of Benefits and Coverage (SBC) & Uniform Glossary

As required by the Patient Protection and Affordable Care Act (Healthcare Reform), the Summary of Benefits and Coverage (SBC) for the medical plan(s) offered and the Uniform Glossary are available on the online enrollment system. You may also request a paper copy from Human Resources.

Privacy Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that your private health information is protected and confidential. This Plan, the Plan Administrator and the Plan Sponsor will not disclose information that is protected by HIPAA, as required by law. To obtain a copy of your HIPAA Privacy Rights, contact your Human Resources Department.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

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

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Point University		4. Employer Identification Number (EIN) 58-6044761
5. Employer address 507 W 10th Street		6. Employer phone number 706-385-1000
7. City West Point	8. State GA	9. ZIP code 31833
10. Who can we contact about employee health coverage at this job? Carson Ellzey		
11. Phone number (if different from above) 706-748-8601	12. Email address Carson.Ellzey@point.edu	

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All full-time employees working 30 or more hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal spouses and children up to age 26.

☐ We do not offer coverage.

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

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

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

NOTES

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**This communication represents a brief summary of the various benefits available to you and is provided for reference only. The actual policies issued by the Insurance Carrier determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace an Employer's requirement for communication.*