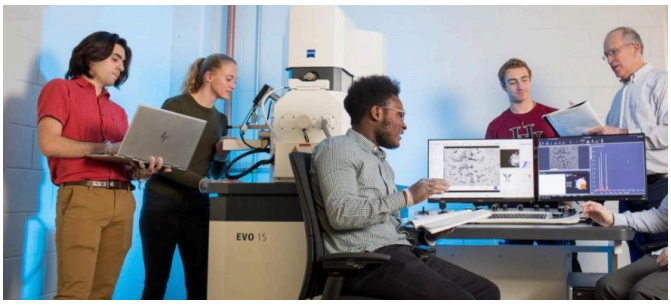
# **2025** | Employee Benefits Guide



HAMLINE UNIVERSITY

# WHAT'S NEW FOR 2025

Here's a quick overview of changes for 2025:

**MEDICAL**
There will be NO increases to employee premiums for 2025. There will also be NO plan changes! The same menu of plans and networks will be offered.

**HEALTH SAVINGS ACCOUNT**
The annual maximum contribution limits are increasing for 2025. The new limits will be:

- Employee Only: $4,300
- Employee + One and Family: $8,550
- Catch Up Contribution: remains at $1,000

Review the HSA section of this guide on **Page 13** to learn more.

**FLEXIBLE SPENDING ACCOUNTS**
The maximum annual contribution level for the Medical and Limited Purpose FSAs is to $3,300.

**FSA CARRYOVER**
Any unused dollars up to $660 in your Medical or Limited Purpose FSAs can be carried over to the following plan year. Funds rollover will occur after the runout period ends on March 31, 2026.

## We are here to help...

The Hamline Benefits Office is available to assist you with any questions you may have. Please do not hesitate to contact us at **651-523-2815**.

You can also visit the **Hamline Benefits Office website** by clicking **HERE**.

*If you are a member of the International Union of Operating Engineers, Local No. 70, you may have certain benefits that are part of your collective bargaining agreement. We encourage you to refer to your labor agreement for guidance.*

# BENEFITS AT A GLANCE

Hamline offers a competitive benefit program that is reviewed annually to ensure it meets the needs of our diverse employee base. See the chart below for a quick look at the information provided in this Benefit Guide. Then, click on the page number in the table below to go to that specific section for more detailed information. Direct yourself back to this page just by clicking the "home" icon in the upper right corner of each page.

| Page # | Benefit Plan | Description |
|---|---|---|
| 2 | General Plan Information | Eligibility, when and how to make changes |
| 4 | Medical | Four options:<br>• Plan A: $6,500 / $13,000-100% HSA Plan<br>• Plan B: $3,500 / $7,000-75% HSA Plan<br>• Plan C: $1,700 / $5,400-$35 Copay Plan<br>• Plan D: $850 / $2,500-$35 Copay Plan |
| 13 | Health Savings Account | Pre-tax savings account for high deductible health plan participants |
| 14 | Medical Flexible Spending Account | Pre-tax account for paying eligible health care expenses |
| 16 | Dependent Care Flexible Spending Account | Pre-tax account for paying eligible dependent day care expenses |
| 17 | Dental | Dental plan with PPO and Premier network provides coverage for preventive, basic and major services, as well as orthodontia for dependent children |
| 18 | Vision | Provides coverage for lenses, frames and/or contacts |
| 19 | Basic Life and AD&D | Hamline provides you with coverage equal to two times annual salary up to the guarantee issue limit |
| 19 | Voluntary Life and AD&D | Additional coverage you may purchase for yourself, your spouse, and/or your children |
| 20 | Long Term Disability (LTD) | Replaces 66-2/3% of base salary for your period of disability |
| 21 | Additional Benefits | Critical Illness<br>Short Term Disability<br>Hospital Indemnity<br>Legal Plan<br>Employee Assistance Program<br>Travel Assistance<br>Medical Bill Saver<br>Will Prep & Life Planning |
| 27 | Terms Defined | Definitions helpful in understanding your benefits |
| 28 | Important Resources | Listing of the resources available to answer questions or provide information about your benefits |

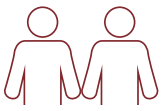
# GENERAL PLAN INFORMATION

As a Hamline employee, you have a variety of benefit options to choose from. This Benefit Guide provides an overview of the plans available to you to help you make informed enrollment decisions.

## ELIGIBILITY

You are eligible to participate in Hamline University's benefit program on the first of the month following your date of hire if you are an active full-time employee. Spouses (opposite and same-sex) and children (up to age 26) are eligible for most benefits.

YOU



YOUR SPOUSE

YOUR CHILD(REN)

| | Full-time 30+ hrs/wk. | Part-time 20+ hrs/wk. | | |
|---|---|---|---|---|
| Medical | ✓ | | ✓ | ✓ |
| Dental | ✓ | ✓ | ✓ | ✓ |
| Vision | ✓ | ✓ | ✓ | ✓ |
| Basic Life Insurance and AD&D | ✓ | | | |
| Voluntary Life Insurance and AD&D | ✓ | | ✓ | ✓ |
| Long Term Disability Insurance | ✓ | | | |
| Health Savings Account | ✓ | | ✓ | ✓ |
| Medical Flexible Spending Accounts | ✓ | | ✓ | ✓ |
| Dependent Care Flexible Spending Accounts | ✓ | ✓ | | ✓ |
| Worksite Benefits – Short Term Disability, Critical Illness, Hospital Indemnity Insurance | ✓ | ✓ | ✓ | ✓ |

## CHANGING YOUR ELECTIONS

The benefit elections you make during your initial or annual enrollment remain in effect for the entire calendar year due to IRS regulations. You are, however, allowed to modify your elections in certain situations, called "**qualifying life events**." If you experience a qualifying life event, you may make changes to your benefits. Please Note: These changes must be made within **30 days** from the event.

A qualifying life event includes a change in:

- **Legal marital status** – marriage, death of spouse, divorce, legal separation, or annulment
- **Number of dependents** – birth, adoption, placement for adoption, divorce or death of a dependent, or assuming primary support of a child of an unmarried dependent child
- **Employment status** – eligible dependent gains or loses access to employer-sponsored coverage
- **Dependent status** – change due to age or other circumstance which causes your dependent to satisfy or cease to satisfy eligibility requirements under the plan
- **Medicare or Medicaid eligible status** – you or your spouse become Medicare or Medicaid eligible.

Any benefit changes must be consistent with the life event you or your family member experienced. The new election becomes effective as of the date of the change in status or loss of coverage, whichever comes later.

You must notify the Benefits Office within 30 days from the qualifying life event to make any changes in your benefits. You may be required to submit documentation.

# MEDICAL INSURANCE

The cornerstone of Hamline's benefits package is medical coverage. Whether you are facing an illness or injury, or simply utilize preventive care, the University offers comprehensive protection against the financial hardship that can accompany a medical need. Read this section to determine which option best meets the needs of you and your eligible dependents.

## MEDICAL PLAN CHOICES

Hamline offers four medical plan options. All options provide high-quality, affordable medical care, including preventive care, doctor's visits, hospitalization, and emergency care. However, each plan has unique characteristics and advantages. The plans are offered through Medica, a non-profit organization providing health coverage to approximately 1.5 million members.

Your choices include:

- Plan A: $6,500 / $13,000 - 100% HSA Plan
- Plan B: $3,500 / $7,000 - 75% HSA Plan
- Plan C: $1,700 / $5,400 - $35 Copay Plan
- Plan D: $850 / $2,500 - $35 Copay Plan

Visit **welcometomedica.com/hamline** for additional information with side-by-side comparisons of the plans. Find a doctor, or review what each plan offers along with some of the value-added benefits.

## HOW THE PLANS WORK

### Plans A & B

These plans require covered participants to meet an annual deductible before the plan will start to pay for covered services – with the exception of preventive care which is covered at 100%. Plan A has a higher deductible, but once a participant has met the deductible, the plan pays 100% of all covered in-network expenses for the remainder of the calendar year. Plan B has a lower deductible, but services are subject to coinsurance once the deductible is met. This means that once you have met your deductible, you will share the cost of care with Medica – called coinsurance – until you reach your out-of-pocket maximum. At that time, the plan will pay 100% of all covered in-network expenses for the remainder of the calendar year.

These two plans are paired with a Health Savings Account through Lively. Participants may contribute to a Health Savings Account (HSA) to help cover out-of-pocket costs on a pre-tax basis. Federal rules limit reimbursement to family members who are tax dependents or a legal spouse.

### Plans C & D

These plans require that you pay a copay for office visits and prescription drugs. Preventive care is covered at 100%. All other covered services, including lab work and x-rays associated with an office visit, are subject to the deductible, coinsurance and out-of-pocket maximum. Plan C has a higher deductible and out-of-pocket maximum than Plan D. The office visit and prescription copay amounts are the same under both plans. Once you've met the annual out-of-pocket maximum, the plans pay 100% of covered services for the rest of the calendar year as long as services are in-network.

To help pay for qualified health care expenses, Plan C and D participants are eligible to contribute to a Medical Flexible Spending Account on a pre-tax basis through payroll deduction. You can use the medical FSA to reimburse expenses for yourself and your legal tax dependents.

## BENEFIT SUMMARY

This is a summary of your benefits, not a complete listing. Please see your Summary of Benefits and Coverage (SBC) for additional details. **NOTE: All Hamline medical plans provide creditable drug coverage.**

| IN-NETWORK | PLAN A | PLAN B | PLAN C | PLAN D |
|---|---|---|---|---|
| Deductible | $6,500 per person<br>$13,000 per family | $3,500 per person<br>$7,000 per family | $1,700 per person<br>$5,400 per family | $850 per person<br>$2,500 per family |
| Out-of-Pocket Maximum | $6,500 per person<br>$13,000 per family | $7,000 per person<br>$14,000 per family | $5.000 per person<br>$10,000 per family | $4,000 per person<br>$8,000 per family |
| PREVENTIVE CARE – ROUTINE | | | | |
| Well-child, adult physical and eye exams / immunizations | 100% coverage | 100% coverage | 100% coverage | 100% coverage |
| PHYSICIAN SERVICES | | | | |
| Physician and specialist visits; urgent care | 100% coverage after deductible | 75% coverage after deductible | $35 copay | $35 copay |
| Convenience care | 100% coverage after deductible | 75% coverage after deductible | $20 copay | $20 copay |
| X-rays & Imaging | 100% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible |
| HOSPITAL SERVICES | | | | |
| Inpatient / Outpatient Hospitalization | 100% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible |
| EMERGENCY SERVICES | | | | |
| Emergency room | 100% coverage after deductible | 75% coverage after deductible | $75 copay | $75 cpay |
| Ambulance | 100% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible |
| MENTAL HEALTH / CHEMICAL DEPENDENCY | | | | |
| Inpatient | 100% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible | 75% coverage after deductible |
| Outpatient | 100% coverage after deductible | 75% coverage after deductible | $35 copay | $35 copay |
| PHARMACY (on Medica formulary) | | | | |
| Retail – up to 31-day supply | 100% coverage after deductible | Generic & Preferred: 75% coverage after deductible<br>Non-Preferred: 55% coverage after deductible | Generic: $12<br>Preferred: $50<br>Non-preferred: $90 | Generic: $12<br>Preferred: $50<br>Non-preferred: $90 |
| Mail Order – up to 93-day supply | 100% coverage after deductible | 75% coverage after deductible | Generic: $24<br>Preferred: $100<br>Non-preferred: $180 | Generic: $24<br>Preferred: $100<br>Non-preferred: $180 |
| Specialty – up to 31-day supply from designated specialty pharmacy | 100% coverage after deductible | Preferred: 75% coverage after deductible, not to exceed $200 copay/ prescription<br>Non-Preferred: 55% coverage after deductible | Preferred: You pay 20% up to $200 maximum;<br>Non-preferred: you pay 40% | Preferred: You pay 20% up to $200 maximum;<br>Non-preferred: you pay 40% |
| **OUT-OF-NETWORK** | **PLAN A** | **PLAN B** | **PLAN C** | **PLAN D** |
| Deductible | $9,525 per person / $19,050 per family | $4,500 per person / $9,000 per family | $2,250 per person / $6,750 per family | $1,125 per person / $3,375 per family |
| Out-of-Pocket Maximum | $12,700 per person / $25,400 per family | $13,000 per person / $26,000 per family | $9,000 per person / $18,000 per family | $7,000 per person / $14,000 family |
| Preventive Care – Routine | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible |
| Physician Services | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible |
| Hospital Services | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible | 50% coverage after deductible |

## PRESCRIPTION DRUG COVERAGE

Medica partners with **Express Scripts, Inc. (ESI)**, as the pharmacy benefit manager (PBM) for health plans across all of Medica's segments. High-cost specialty drug management is provided (through Accredo) or medical pharmacy management (through Magellan). Covered drugs are listed on the Medica Preferred Drug List, which is comprised of drugs that provide the most value and have proven safety and effectiveness.

How you pay for your prescriptions will vary by your plan choice and where you fill your prescription.

- **Retail Pharmacy** – Participants in Plans A and B are responsible for the full cost until the deductible has been met. Once the deductible is met, then the plan pays 100% for the remainder of the calendar year. Participants in Plans C and D pay a based on the type of drug purchased.

- **Mail Order Pharmacy** – Express Scripts, Inc. is Medica's prescription mail order provider. Mail order provides the convenience of receiving a 3-month supply mailed directly to your home. Plan C and D participants also get a 3-month supply for the cost of two (2) copays. Before deciding if mail order is right for you, compare prices using the Medica Price a Medication tool available on **www.Medica.com/SignIn**. Members will be able to easily start, manage and refill eligible mail order prescriptions using the Express Scripts website (accessible through Medica.com/SignIn.com) or the Express Scripts mobile app. You can also contact Express Scripts Pharmacy 24/7 by phone at **1.800.263.2398**.

Tools and resources are available on **www.Medica.com/SignIn**, as well as a mobile app, that makes it easy for you to check drug costs, locate pharmacies and view your prescription history.

- **93-Day Refill Option** – You can get up to a 93-day supply of ongoing medications from a participating pharmacy with the 93-day refill option. You'll pay three retail copayments or coinsurance amounts (depending on your plan) and get the convenience of saving trips to the pharmacy. To use this option, ask your provider for a 93-day prescription and bring it to a participating pharmacy.

- **Specialty Drugs** – These medicines treat health care conditions like cancer, hepatitis, multiple sclerosis and rheumatoid arthritis. Medications considered "specialty" drugs must be filled through an approved specialty pharmacy or there will be no coverage.

- **Accredo** – Medica partners with Accredo to provide specialty pharmacy services. The Accredo clinical team offers one-on-one counseling and assistance as well as opportunities to engage through web, mobile, text, chat and email to make refilling medications as easy as possible. Specialty medications are conveniently delivered to members via FedEx or UPS. You can contact Accredo by phone at **1-877-ACCREDO (222-7336)** or access their website: **www.accredo.com**

## YOUR NETWORK OPTIONS

It is in your best interest to seek providers who are in-network. If you see a provider that is not in your Medica network, your costs will be significantly higher because you receive a lower coverage amount under your benefit plan – and your share of the costs is based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. Also, costs that exceed the usual and customary (U&C) rate are not subject to the out-of-pocket maximum. So once the total of your out-of-network U&C charges reach your out-of-pocket maximum, the plan will pay 100% of the remaining U&C charges, but you continue to pay the full cost of any charges above U&C.

The following is a brief description of the **networks** available to you:

- **Choice Passport** – Medica's largest, national network has access to more than 1 million providers and nearly 7,300 hospitals across the U.S. For care received within the Medica service area, you have the Medica Choice Passport open access network. For care received outside of the Medica service area (students, while traveling, etc.) you have access to the UnitedHealthcare national network. You are free to see any provider in the Medica network (without a referral) and you are not required to select a primary care clinic.
- **Elect** – A separate, smaller network of providers delivering services at lower rates. You save money on your monthly premium, as well as the services you receive. For care received outside of the Medica service area (students, while traveling, etc.) you have access to the UnitedHealthcare national network (see next page for specifics).

  The network has a number of "care systems", a group of primary care clinics, specialists and hospitals. **You choose a primary care clinic, within a care system, to be your medical home.** You do not need referrals within your care system, but referrals can be issued outside of the care system.
- **VantagePlus** – A combination of several major care systems and independent providers offering a broad geographic access and a greater focus on lowering health care costs and improvements in service. It provides direct access to more than 4,800 providers, 650 clinics, and 11 hospitals.

**KEEP IN MIND** – If you are traveling or have family members who live away from home – a child at school, for example – emergency services will always be considered in-network. For children away at school, coverage for routine services like physical therapy or office visits for the flu or an ear infection will depend on where they are located in relation to the Medica service area (Minnesota, North Dakota, South Dakota and western Wisconsin), as follows:

**Inside the service area:**
Routine services will be considered out-of-network unless they are received from a provider in their Elect or VantagePlus care system.

**Outside the service area:**
Routine services will be considered in-network as long as they are delivered by a UnitedHealthcare provider. Keep in mind, however, that chiropractic services are not included outside the Medica service area. Your out-of-network benefits would apply in this case.

| ELECT NETWORK | | VANTAGEPLUS NETWORK |
|---|---|---|
| Allina Medical Clinics<br>Children's Health Network<br>Integrity Health Network<br>Hennepin Health<br>Park Nicollet Health Services | RiverWay / North Suburban Clinics<br>St. Luke's<br>Lakeview Medical Group<br>Minnesota HealthCare Network | M Health Fairview*<br>North Memorial<br><br>* HealthEast has now integrated with Fairview Health Services |

## REFERRALS

A referral is a written recommendation from your primary care clinic to see a specialist outside of your care system. If your care system can't deliver the care you require, your primary care clinic will write you a referral. Your primary care clinic will notify Medica that you have a referral so the care will be considered in-network.

The referral will list the:

- Name of the specialist
- Type of service
- Number of visits
- Date range when you can see the specialist

Please note that your referral provider cannot refer you on to another specialist, this would need to be coordinated by your primary care clinic. However, if your referral says that the specialist can "consult, diagnose and treat" then the specialist can order services such as physical therapy, imaging (X-rays, CT scans, etc.), outpatient surgery and other related care.

Some services can be accessed outside of your care system, as long as they are in your network. Examples would be chiropractic care, convenience care, urgent care, or durable medical equipment. If you have questions regarding referrals (or the need for a referral), contact Medica Customer Service at **800.952.3455**.

**ELECT NETWORK: Designating or Changing a Primary Care Clinic**

When you enroll in the Elect network, you will need to designate a primary care clinic (PCC) for each member of your family. Please note that each family member can choose their own primary care clinic, and they do not need to be within the same care system.

## FINDING A PROVIDER

The Medica website provides help when you need to find a network provider or Primary Care Clinic.

**To find a network provider**
Go to **welcometomedica.com/hamline** OR **medica.com/find-care/select-employer-provided-plan**

- Select the network you wish to search:
  - Medica Choice Passport*
  - Medica Elect
  - VantagePlus

- Search for providers by name, facility, specialty, or condition to find doctors who treat specific conditions.

**NOTE:** If you enroll in the VantagePlus network, you will be automatically assigned the VantagePlus PCC# upon enrollment. You do not need to enter it on your own (there is only one option so there is also no need to attempt to change it once enrolled).

* If using Medica's website direct, if asked, please select **Medica Choice with UnitedHealthcare Choice Plus**.

**To find a Primary Care Clinic (PCC)**
***Elect network ONLY***
Follow the instructions of the previous first two bullets, then:

- Under the "**What are you looking for today?**" section, click on Physician and Facilities. Select Facilities and Services. Type in your zip code and click on "**Clinic-Primary Care.**"
  - You can narrow your results by entering your address or choosing a care system, specialty or other criteria.

- In your results, look for the clinic's Care System listing – that's where you will find the clinic's PCC ID – which is the number you will use to designate the clinic as your PCC when you enroll.
  - A PCC ID looks like this (PCC ID: 00000000123).
  - If no PCC ID is displayed, you cannot choose that clinic as your primary care clinic.

For assistance locating a Primary Care Clinic or selecting a Care System, call Medica Customer Service at **800.952.3455**.

## VIRTUAL CARE OPTIONS

You can access virtual care through providers in your plan's network. Check your virtual care options at **medica.com/findadoctor**. Your virtual care options may include:

### Amwell

24/7 online clinic available in every state.

#### Services

- Treatment of common medical conditions. Visits are typically a lower cost option to an in-person visit, depending on your plan's coverage for virtual care.
- Behavioral health care services including therapy and psychiatry. Cost per visit may vary depending on your plan and type of service. Eligible services are covered under your plan as a behavioral health office visit.*
- Amwell also offers other online services, but it's not an in-network provider for those services. You can use those services, but you will pay the full cost.

#### How it works

You have a video visit with a board-certified doctor or nurse practitioner using using the web or mobile app.

1. To get started, create an account with Amwell.
   **Smartphone/tablet**: Download the free Amwell app from the Apple Store or Google Play.
   **Computer:** Go to **amwell.com/cm.**
   **Phone:** Call 1(844) 733-3627.
2. Enter your email address, create a password, then add the requested insurance information from your Medica ID card.
3. Select a doctor or nurse practitioner and follow the prompts to start your visit.
4. The doctor will review your history, answer questions, diagnose, treat and prescribe medication (if needed).
5. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

### Virtuwell

24/7 online clinic available in select states.**

#### Services

- Treatment of common medical conditions. Check the virtuwell website for current pricing. Visits are typically a lower cost option to an in-person visit, depending on your plan's coverage for virtual care.

#### How it works

You have an online visit with a certified nurse practitioner.

1. Go to **virtuwell.com** and take a quick online interview that checks your medical history and makes sure your problem can be treated online.
2. If you can be treated online, you'll create an account with your contact, insurance, pharmacy, and payment information.
3. A nurse practitioner will review your case and write a personalized treatment plan. You'll get an email or text when your plan is ready.
4. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's coverage for prescription drugs.

#### COMMON CONDITIONS FOR VIRTUAL CARE

- Allergies
- Sinus infection
- Bladder infection
- Bronchitis and flu
- Cold and cough
- Ear pain
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Other non-urgent conditions

* To check your plan's coverage for behavioral health, sign in to your member account at **Medica.com/SignIn** or call the number on the back of your Medica ID card.

** Visit **virtuwell.com** for a list of available states.

## MEDICA WELLNESS DISCOUNTS AND RESOURCES

Medica has a wealth of discounts and resources available for members:

**Behavioral Health Support**
Connect with on-demand help for stress, depression and anxiety through **Self Care by AbleTo**. Download the AbleTo app to access coping tools, daily mood tracking, guided journeys and weekly progress check-ins to stay engaged and manage symptoms. You receive premium access as part of your plan's behavioral health benefits.

**Omada**
Empowers you to build healthy behaviors that last. Omada is a digital lifestyle change program for people at risk for chronic conditions like prediabetes, hypertension, high cholesterol and cardiovascular disease. Participants learn how to make meaningful changes and sustain behaviors. Medica members (ages 18+) who are at risk for diabetes or heart disease may be eligible to participate at no cost. To find out if you are at risk and eligible to participate, complete a short health assessment at **OmadaHealth.com/Medica**.

**Value for Your Health Care Dollar**
Cost and quality can vary significantly among providers. Knowing the difference can help you save money and have better results. Look up cost ranges for common procedures at dozens of facilities using **Main Street Medica**. Or use the online provider search tool to find doctor-specific cost and quality information with Premium Designation. Both tools are available on **Medica.com/SignIn**.

**My Health Rewards Program**
Taking steps to improve your health might be easier than you think. Whether you want to stress less, quit smoking or eat more fruits and veggies, **My Health Rewards by Medica**® makes it fun — and rewarding. You'll earn rewards as you complete activities personalized just for you. To get started with My Health Rewards, download the Personify Health app (formerly Virgin Pulse), free in the App Store or on Google Play.

**24-Hour Health Support**
Worried that your stomach bug could be serious? Wondering what to do about that cough that won't go away? The advisors and nurses at **Medica CallLink**® can help. They're available 24 hours a day, 365 days a year to answer your questions and help you make smart decisions about your health. Just call **1(800)962-9497** (TTY users, call 711).

## COST OF MEDICAL COVERAGE (MONTHLY PREMIUMS)

| | PASSPORT | | ELECT | | VANTAGEPLUS | |
|---|---|---|---|---|---|---|
| **Plan/Tier** | **Employer Contribution** | **Employee Contribution** | **Employer Contribution** | **Employee Contribution** | **Employer Contribution** | **Employee Contribution** |
| **Plan A** | | | | | | |
| Employee | $687.89 | $89.87 | $610.89 | $69.65 | $593.69 | $67.40 |
| Employee+1 | $1,396.11 | $353.85 | $1,249.15 | $282.07 | $1,214.49 | $272.97 |
| Family | $1,424.02 | $605.92 | $1,267.23 | $508.97 | $1,232.89 | $492.55 |
| **Plan B** | | | | | | |
| Employee | $665.02 | $130.65 | $610.44 | $85.77 | $593.31 | $83.00 |
| Employee+1 | $1,167.74 | $622.51 | $1,051.86 | $514.61 | $1,023.71 | $498.01 |
| Family | $1,354.57 | $722.11 | $1,145.54 | $671.56 | $1,115.28 | $649.90 |
| **Plan C** | | | | | | |
| Employee | $773.17 | $212.66 | $736.75 | $125.86 | $716.17 | $121.80 |
| Employee+1 | $1,217.66 | $1,000.46 | $1,111.56 | $829.30 | $1,082.85 | $802.55 |
| Family | $1,412.48 | $1,160.53 | $1,289.41 | $961.98 | $1,256.11 | $930.95 |
| **Plan D** | | | | | | |
| Employee | $667.75 | $365.99 | $565.01 | $339.51 | $549.29 | $329.40 |
| Employee+1 | $861.94 | $1,463.97 | $740.79 | $1,294.38 | $721.21 | $1,255.81 |
| Family | $999.85 | $1,698.20 | $859.39 | $1,501.48 | $836.60 | $1,456.73 |

# HEALTH SAVINGS ACCOUNT

If you enroll in Plans A or B, you can contribute to an HSA on a pre-tax basis through payroll deduction. Annual contributions are limited by federal law depending on the level of health coverage you elect. You can start, stop or change your HSA contribution at any time during the year.

## ELIGIBILITY

Because of the tax-advantaged nature of an HSA, there are specific eligibility requirements, including:

- You may NOT be covered by another non-HDHP health plan (for example, a spouse's traditional medical plan that covers you).
- You and your spouse may NOT enroll in a medical Flexible Spending Account that could reimburse your medical expenses. Participation in a limited Flexible Spending Account that covers only dental and vision expenses is allowed.
- You may NOT be enrolled in a government health plan, such as Medicare A and/or B or Medicaid.
- Children who are NOT your tax dependents are not eligible for reimbursement from the HSA.
- You may NOT have an HSA and be claimed as a dependent on someone else's tax return.

## USING YOUR HSA

Funds can be used to pay for:

- Qualified medical expenses
- Qualified dental, vision and hearing expenses
- COBRA continuation coverage if you leave employment with the University
- Qualified long-term care insurance

Funds can also be used to build savings to cover future medical expenses on into retirement, including Medicare premiums and out-of-pocket expenses.

HSA participants receive an HSA debit card, which may be used to pay for qualified health care expenses directly. Or, you may reimburse yourself from your HSA at a later date. You own the amount in your account and may take it with you if you leave Hamline.

You do not need to provide proof of your expense to Lively. However, you should keep your receipts in case you are audited and need to provide proof that your withdrawals were for qualified medical expenses.

Tax reporting is required for the HSA. IRS form 8889 **must** be completed with your tax return each year to report total deposits and withdrawals from your account (you do not have to itemize to complete this form).

For additional information, contact Lively customer service at **1.888.576.4837** or **livelyme.com**. You can also email **support@livelyme.com** with questions.

| COVERAGE LEVEL | ANNUAL MAXIMUM CONTRIBUTION | CATCH-UP CONTRIBUTION IF AGE 55+ |
|---|---|---|
| Employee Only | $4,300 | $1,000 |
| Employee +1 | $8,550 | $1,000 |
| Family | $8,550 | $1,000 |

## MANAGING YOUR HSA

It's easy to manage your HSA using the Lively portal at **livelyme.com**. You can check your account balance, view account activity, reimburse yourself, or designate a beneficiary. You can also download the "Lively HSA & FSA" mobile app which allows you to manage your HSA on the go.

**You will be charged a $1.25 monthly administration fee.**

**NOTE:** Changing your contribution amount during the year can be done in Workday.

# MEDICAL FLEXIBLE SAVINGS ACCOUNT

The Medical Flexible Spending Account gives Plan C or D participants the opportunity to set aside pre-tax dollars to pay for qualified medical, dental and vision expenses. Examples of eligible expenses include deductibles and copays, prescription drug costs, over-the-counter medicines (if prescribed by a doctor), and other non-covered medical, dental, vision and hearing care expenses.

Plan A & B participants can contribute to a **Limited Purpose Flexible Spending Account** for dental and vision expenses ONLY.

## FSA CONTRIBUTIONS

You may contribute up to $3,300 to your Medical FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies for any amount above $660 remaining in your account. Any unused amount exceeding this at the end of the year will be forfeited. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on **page 3**.

### FSA CARRYOVER

Any unused dollars up to $660 in your Medical or Limited Purpose FSAs can be carried over to the following plan year. Rollover will occur after the runout period ends on March 31, 2026.

### MANAGING YOUR FSA

Visit **app.thrivepass.com** to file a claim, check account balance and claim status, view account history, access forms and manage your profile

## USING YOUR FSA

You can pay for eligible expenses in one of two ways:

- **Debit card:** Use the debit card to pay for eligible health care expenses at the point of service or write your debit card number on your provider's bill – just as you would a credit card. Funds will be taken directly from your ThrivePass medical FSA account.
- **FSA claim form:** Pay the provider directly and then file a claim for reimbursement. You will need to complete an FSA claim form and submit it to ThrivePass along with your receipts.

**NOTE:** Expenses must be incurred between January 1, 2025 and December 31, 2025. You will have until March 31, 2026 to submit claims.

## COMPARING FSA AND HSA ACCOUNTS

| | HSA | MEDICAL FSA |
|---|---|---|
| Who can have this plan? | Plan A & B participants | Plan C & D participants; Plan A & B participants with an HSA can have a limited purpose FSA only |
| What is the contribution limit? | Employee Only: $4,300<br>Employee + 1 or Family: $8,550 | $3,300 |
| Can I make a catch-up contribution? | Yes, up to $1,000 for 2025 if you are age 55+ and not enrolled in Medicare | No |
| What are the tax advantages? | • Contributions are tax-free<br>• Investment earnings on balance are tax-free<br>• Withdrawals for eligible expenses are never taxed | • Contributions are tax-free<br>• Withdrawals for eligible expenses are never taxed |
| What expenses are eligible? | Any out-of-pocket expenses for medical, prescription drugs, dental, vision and hearing | |
| Can I make a contribution change? | Yes, allowed throughout the year at anytime | Maybe, changes are only allowed if you have a Qualifying Life Event **(see page 3)** |
| How can I use the funds? | You can spend them now on eligible health care expenses, or save for future health care expenses | You need to spend them on eligible health care expenses incurred in the year designated |
| Is there a time limit for using fund balance? | No limit | You must file your 2025 claims by March 31, 2026 |
| Can I roll-over my unused funds from year to year? | Yes | Yes, any unused funds up to $660 can rollover |
| What funds are available to reimburse expenses? | Limited to your current account balance | Entire contribution amount elected for the year |
| Do I need to provide proof my expense? | No, proof is not required by Lively; if you are audited by the IRS proof will be required, so keep your receipts | Yes, proof is required by ThrivePass for one-time expenses; no proof after initial substantiation for recurring expenses or for copay amounts |

# DEPENDENT CARE FSA

The Dependent Care Flexible Spending Account allows employees to set aside pre-tax dollars to pay for eligible dependent daycare expenses. Contributions are automatically deducted from your paychecks on a pre-tax basis, saving you money by not paying federal, state or Social Security taxes on the portion of your income that you contribute to the plan.

## HOW THE PLAN WORKS

This account is for eligible work-related daycare expenses. Eligible dependents include children under age 13 and disabled dependents of any age who are incapable of self-care. You can use the funds to pay for daycare, preschool, summer camp, before/after school programs or eligible senior centers while you (and your spouse) are actively working or attending school. The primary purpose should be to provide for the dependent's well-being and protection. Education-focused expenses that can be separated from daycare expenses are not eligible.

By law, any unused funds are forfeited after year-end. You may not carry a balance over to the next year. So estimate your eligible expenses carefully and conservatively.

## FSA CONTRIBUTIONS

You may contribute up to $5,000 ($2,500 if married and filing separately) to your Dependent Care FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies. This means that if you have not incurred enough expenses to reimburse the funds in your account at the end of the year, your remaining account balance will be forfeited. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on page 3.

### MANAGING YOUR DEPENDENT CARE FSA

Visit **app.thrivepass.com** to file a claim, check account balance and claim status, view account history, access forms and manage your profile

## USING YOUR FSA

When you have incurred dependent care expenses, you must submit a claim for reimbursement – along with proof of the expense. The claim form can serve as a receipt for payment if you have your provider sign the Provider Certification section of the form. Or, you can attach a third-party receipt or billing statement as proof of the expense (canceled checks are not acceptable). The form requires that you provide the federal tax identification number of each provider.

**NOTE:** Expenses must be incurred between January 1, 2025 and December 31, 2025. You will have until March 31, 2026 to submit claims.

# DENTAL INSURANCE

Staying healthy includes good dental care. Hamline's dental plan provides the comprehensive coverage necessary to help you and your family maintain good dental health. The dental benefit is administered by Delta Dental.

For more plan information, such as the average cost of dental procedures, claims information, or to print an ID card, go to **deltadentalmn.org**.

## HOW THE PLAN WORKS

Plan participants have the flexibility to see any dentist they choose. But greater discounts and benefits are available by seeing an in-network dentist. The provider options include:

- Delta Dental Premier – larger network; discounts
- Delta Dental PPO – smaller network; larger discounts
- Out-of-Network – all other providers; no negotiated discounts

**What is "Allowed Amount"?** — This is a term for the negotiated rate that Delta Dental has set with network providers for a specific service. Out-of-network providers may charge more than the allowed amount, leaving you responsible for the difference in cost.

## FINDING NETWORK PROVIDERS

Dentists who participate in the Delta networks will:

- Save the participant and the plan money,
- File claims on behalf of the covered participant, and
- Agree not to charge more than the plan's negotiated rates (or "allowed amount").

To find in-network preferred providers, go to **www.deltadentalmn.org**, select "members," click "Find a Dentist," then "Get Started."Enter your zip code and the distance you are willing to travel to find a provider in your area. Or you can also call **1.800.448.3815**.

| MONTHLY PREMIUMS | |
|---|---|
| Single: $23.82 | Family: $61.96 |

## BENEFIT SUMMARY

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** | None | $50 per person, $150 per family |
| **Annual Plan Maximum** | $2,000 combined | $1,500 combined |
| **Diagnostic and Preventive**<br>Exams & cleanings; x-rays; fluoride treatments; space maintainers; sealants | Covered at 100% | 100% of plan's allowed amount, no deductible |
| **Basic Services**<br>Emergency treatment; fillings | Covered at 80% | 80% of plan's allowed amount after deductible |
| **Endodontics**<br>Root canal therapy | Covered at 50% | 50% of plan's allowed amount after deductible |
| **Periodontics**<br>Surgical /non-surgical treatment of gum tissue | Covered at 50% | 50% of plan's allowed amount after deductible |
| **Oral Surgery**<br>Surgical/non-surgical extractions; all other oral surgery | Covered at 50% | 50% of plan's allowed amount after deductible |
| **Major Restorative**<br>Crowns, inlays and onlays | Covered at 50% | 50% of plan's allowed amount after deductible |
| **Prosthetics Repairs and Adjustments**<br>Dentures and bridges | Covered at 50% | 50% of plan's allowed amount after deductible |
| **Orthodontics**<br>For covered dependents to age 19 | Covered at 50% up to $750 lifetime maximum | |

# VISION PLAN

Hamline offers a vision plan administered by EyeMed. This coverage is a voluntary benefit that features coverage for prescription glasses and contact lenses, as well as other vision-related items.

To find network providers, view your benefits and claims information or see special offers, go to **eyemed.com**. Under "choose your network" select the Insight Network. To access a list of Lasik providers, go to **eyemedlasik.com** or call 877-5LASER6.

## HOW THE PLAN WORKS

You have the freedom to receive services from any provider. However, you will receive a greater level of benefit if you use a provider who participates in the EyeMed Insight network. By using a network provider, you may also receive discounts for services not otherwise covered by the vision plan (i.e., sunglasses and laser vision correction).

| MONTHLY PREMIUMS | |
|---|---|
| Employee Only: | $5.30 |
| Employee + Spouse: | $10.08 |
| Employee + Child(ren): | $10.61 |
| Family: | $15.60 |

**NOTE:** This plan provides coverage for materials and hardware only. Coverage for routine annual vision exams are provided through your Medica medical plan as a preventive appointment.

## BENEFIT SUMMARY

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Eyeglass Lenses* | | |
| Standard Single Vision | $0 copay | Reimbursed up to $30 |
| Standard Bifocal | $0 copay | Reimbursed up to $50 |
| Standard Trifocal | $0 copay | Reimbursed up to $70 |
| Standard Lenticular | $0 copay | Reimbursed up to $70 |
| Standard Progressive | $65 copay | Reimbursed up to $50 |
| Premium Progressive | | |
| Tier 1 | $85 copay | Reimbursed up to $50 |
| Tier 2 | $95 copay | Reimbursed up to $50 |
| Tier 3 | $110 copay | Reimbursed up to $50 |
| Tier 4 | $65 copay; 80% of charge less $120 allowance | Reimbursed up to $50 |
| Frames | $0 copay; $150 allowance; 20% off balance over $150 | Reimbursed up to $105 |
| Contact Lenses | | |
| Conventional | $0 copay; $130 allowance; 15% off balance over $130 | Reimbursed up to $130 |
| Disposable | $0 copay; $130 allowance | Reimbursed up to $130 |
| Medically Necessary | $0 copay; Paid-in-full | Reimbursed up to $210 |
| Laser Vision Correction | 15% off the retail price or 5% off the promotional price | N/A |
| Frequency | **Lenses or Contact lenses:** Once every 12 months** **Frames:** Once every 24 months | |

* *Please refer to the plan document for additional lens options and corresponding copays or % discounts (if applicable).*

** *Contact lenses are in lieu of eyeglass lenses and frames. Members may, however, still be able to receive additional discounts off another complete pair of eyeglasses or conventional contact lenses once the covered benefit has been used.*

# LIFE AND AD&D INSURANCE

You can't always predict – or control – your life. But, you can prepare for it. Protecting the financial interests of your loved ones in the event of your death or serious injury can be invaluable. Hamline covers the cost of Life and AD&D (accidental death or dismemberment) insurance. These benefits are offered through Unum. The plan provides:

- **Basic Term Life and AD&D** – Eligible employees automatically receive the basic portion of the Life and AD&D benefit – there are no choices to be made. Per IRS regulations, you pay tax on the premium paid by Hamline for coverage over $50,000. Any benefits paid out are tax-free to the recipient.
- **Voluntary Life and AD&D** – You decide if you want to purchase voluntary coverage. You need to choose the level of coverage and who you want to cover – yourself, your spouse and/or your dependent children.

## HOW THE PLAN WORKS

Life benefits are payable to your designated beneficiary in the event of your death. An additional AD&D benefit is payable to you in the event of a covered dismemberment or to your beneficiary if your death is the result of an accident.

**Buy-in, Buy-up** – If you enroll at any coverage amount during initial eligibility, you can purchase up to the Guarantee Issue Amount during future annual enrollments.

**NOTE:** You must purchase coverage for yourself in order to elect coverage for your spouse and/or child(ren). Children are eligible to participate up to age 19 (or age 26 if a full-time student).

## BENEFIT SUMMARY

| | BASIC TERM LIFE/AD&D | VOLUNTARY LIFE/AD&D | | |
|---|---|---|---|---|
| | | EMPLOYEE | SPOUSE | CHILD(REN) |
| Benefit Amount | 2 x annual salary<br>- Minimum: $10,000<br>- Maximum: $500,000 | Lesser of 5x annual earnings or $500,000 in increments of $10,000<br>*Note: Maximum is $50,000 for age 70+* | $250,000, may not exceed 100% of the employee amount in increments of $5,000 | $10,000 in increments of $2,000 |
| Guarantee Issue* | $500,000 | $200,000 | $50,000 | $10,000 |
| Age Reduction | - At age 65, benefit reduces to 65% of the original amount<br>- At age 70, inforce coverage reduces to 50% of original amount | - At age 70, benefits will reduce to 65% of the original amount<br>- At age 75, inforce coverage will reduce to 50% of original amount | | |

** Guarantee Issue (GI) refers to the amount of coverage you can purchase without providing evidence of good health. Guarantee Issue applies to life insurance ONLY. There are **no** GI requirements for AD&D.*

## COST OF VOLUNTARY LIFE AND AD&D COVERAGE

You pay the full cost for additional life and AD&D coverage on an after-tax basis. Cost for life coverage for employee and spouse is based on the employee's age. The cost for AD&D is a set amount, shown below:

| VOLUNTARY LIFE/AD&D MONTHLY RATES – PER $1,000 OF COVERAGE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | <30 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75+ |
| Life | $0.04 | $0.05 | $0.08 | $0.12 | $0.20 | $0.34 | $0.54 | $0.72 | $1.16 | $2.05 | $3.50 |
| AD&D | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 | $0.03 |
| Dependent Child(ren) | $0.18 Life $0.03 AD&D | | | | | | | | | | |

# LONG TERM DISABILITY INSURANCE

Being disabled doesn't mean that your income has to stop. Hamline's disability program is designed to replace a portion of your income if you are unable to work due to a non-work related accident or sickness.

## HOW THE PLAN WORKS

Employees may be eligible for disability payments if they are unable to perform their job due to a non-work related injury or illness. Disability benefits are insured through Unum, and all disability claims are reviewed and approved by Unum.

## EVIDENCE OF INSURABILITY

It is strongly encouraged that faculty and staff who are interested in having Long Term Disability coverage enroll when they are first eligible. This is the best way to maximize your benefit without needing to answer health questions.

***Any*** election after initial eligibility will be treated as a late entrant and evidence of insurability requirements will need to be satisfied in order to have coverage.

## YOUR COST

You and Hamline share the cost of long term disability coverage 50% Hamline / 50% employee. The cost of coverage is $0.39 per $100 of covered monthly earnings.

**Calculation Example:**
This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Cost Example – Employee Portion

| EXAMPLE | JOHN DOE | YOU |
|---|---|---|
| Monthly Earnings | $5,000 | $ |
| Multiplied by the rate factor – 0.00195 | $5,000 x .00195 | $____ x .00195 |
| Estimated Monthly Premium | $9.00 | $ |

*This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.*

## BENEFIT SUMMARY

| | |
|---|---|
| When do benefits start? | Qualifying benefits begin after 90 days if you remain disabled according to the terms of the plan |
| How long will the plan pay a benefit? | Until your disability ends or you reach Social Security Normal Retirement Age |
| How much will I receive? | 66-2/3% of base salary (up to $10,000 a month) |
| Will I have to pay taxes on the benefit I receive? | You will pay tax on the 50% employer paid portion; the 50% employee-paid portion will be received tax-free |
| What if I receive other benefit payments? | Your LTD benefit will be offset by any other disability payments, like Social Security or Worker's Compensation |
| Is there anything that would stop me from receiving a benefit? | Pre-existing condition limitations apply (3 months prior to/12 months after initial enrollment) and your disability must be approved by Unum on a periodic basis |
| How can I use the funds? | You can spend them now on eligible health care expenses, or save for future health care expenses |
| Is there a time limit for using fund balance? | No limit |

# CRITICAL ILLNESS INSURANCE

Voluntary Critical Illness insurance through Unum is offered to all benefit eligible employees who work at least 20 hours per week.

Heart attack, stroke, cancer and other illnesses can affect not only your health but also your bank account; medical expenses reportedly lead to more than half of all bankruptcies in the United States. When faced with a severe illness and the accompanying medical costs, Critical Illness insurance can help

Critical Illness insurance is offered as a voluntary benefit to supplement your regular medical coverage. This insurance is designed to cover out-of-pocket expenses not covered by your health insurance, such as your deductible and copays as well as any out-of-network charges. Illness can often lead to extended time away from work, and critical illness benefits can offset some of those lost wages and help you pay routine living expenses such as child care, transportation and rent or mortgage payments. If you don't want to drain your savings because of medical bills and time away from work, critical illness insurance can protect you from financial loss.

**Portability:** You can continue your coverage on a direct-bill basis at the same rates if you leave employment at Hamline.

## PLAN DETAILS

| | |
|---|---|
| Covered Conditions | **Receive 100% of the benefit amount for:** Cancer, Heart Attack, Blindness, Major Organ Failure, End-stage Kidney Failure, Benign Brain Tumor, Stroke (who's effects are confirmed at least 30 days after the event), and Permanent Paralysis (at least two limbs due to covered accident).<br><br>**Receive 25% of the initial benefit amount:** Coronary Artery Bypass Surgery, and Carcinoma in Situ (defined as cancer that involves only cells in the tissue in which it began and has not spread to nearby tissues). |
| Employee Benefit | Choose your benefit amount: $5,000 to $50,000 in increments of $5,000. Coverage up to $10,000 is guaranteed without evidence of insurability when enrolling when first eligible. |
| Spouse Benefit | Spouses from ages 17 to 64 can get $5,000 of coverage without medical questions (when first eligible) as long as you purchase coverage for yourself. The maximum spousal benefit is $30,000, but evidence of insurability will apply. |
| Child Benefit | Dependent children from newborn to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of the coverage you elect.<br>They are covered for all of the same illness listed, plus specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, and spina bifida. |
| Pre-Existing Conditions | 12/12: Any sickness or injury or symptoms of a sickness or injury for which you received medical treatment, consultation, care or services during the 12 months prior to the effective date will not be covered for a period of 12 months. |
| Wellness Benefit | Every year, each covered family member on the Critical Illness plan can also receive $50 simply for getting a health screening test, such as: chest X-rays, stress tests, colonoscopy, mammograms, blood tests, pap smear, and more! |

# CRITICAL ILLNESS INSURANCE

| MONTHLY PREMIUM* - PER $1,000 OF COVERAGE | | |
|---|---|---|
| ISSUE AGE | NON TOBACCO | TOBACCO |
| <25 | $0.39 | $0.56 |
| 25-29 | $0.43 | $0.68 |
| 30-34 | $0.63 | $1.01 |
| 35-39 | $0.86 | $1.49 |
| 40-44 | $1.22 | $2.17 |
| 45-49 | $1.68 | $3.01 |
| 50-54 | $2.20 | $4.01 |
| 55-59 | $2.89 | $5.11 |
| 60-64 | $3.71 | $6.13 |
| 65-69 | $4.17 | $6.38 |
| 70+ | $7.48 | $10.29 |

*Calculate your rate above based on your intended benefit and then add an additional $1.60 for the mandatory wellness benefit.

**Premium Example:**
The following calculation is based on a $10,000 benefit level for a 38-year-old non-tobacco user.

| | |
|---|---|
| Cost per $1,000 | $0.86 |
| # of $1,000 increments | x 10 |
| Monthly premium | $8.60 |
| Wellness benefit cost | $1.60 |
| TOTAL Monthly Costs | $10.20 |

# HOSPITAL INDEMNITY INSURANCE

Hamline offers Voluntary Hospital Indemnity insurance through Unum to all benefit eligible employees who work at least 20 hours per week.

Hospital Indemnity insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur.

Hospital Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed, regardless of the actual cost of treatment.

**Portability:** You can continue your coverage on a direct-bill basis at the same rates if you leave employment at Hamline.

## PLAN DESCRIPTION

| | INSURANCE PAYS YOU |
|---|---|
| Hospital Admission | $1,000 per insured once per year |
| Daily Hospital Confinement | $100 per day, to a maximum of 65 days once per year |
| Intensive Care | $200 per day, to a maximum of 20 days once per year |
| Portability | Included, you can take this policy with you if you leave employment |
| Family Coverage Options | Employee, Spouse, Child |
| Rates | Issue age; unisex |
| Evidence of Insurability | Employees that do not enroll when first eligible, will need to complete evidence of insurability. |
| Pre-existing Condition | 12/12: Any sickness or injury or symptoms of a sickness or injury for which you received medical treatment, consultation, care or services during the 12 months prior to the effective date will not be covered for a period of 12 months. |

| MONTHLY PREMIUMS* | | | | |
|---|---|---|---|---|
| ISSUE AGE | EMPLOYEE ONLY | EMPLOYEE + SPOUSE | EMPLOYEE + CHILDREN | EMPLOYEE + SPOUSE AND CHILDREN |
| 17-49 | $12.07 | $24.25 | $18.23 | $30.41 |
| 50-59 | $15.90 | $32.85 | $22.06 | $39.01 |
| 60-64 | $22.33 | $46.27 | $28.49 | $52.43 |
| 65+ | $33.78 | $70.22 | $39.94 | $76.38 |

***Actual cost may vary:** Employee + Spouse and Employee + Spouse and Children coverage assume the employee and spouse are in the same age band. If in a different age band, the final rate will be different than shown.

# SHORT TERM DISABILITY INSURANCE

Hamline offers Voluntary Short Term Disability insurance through Unum to all benefit eligible employees who work at least 20 hours per week.

Many people live paycheck to paycheck. In the event of a covered injury or illness occurring, Short Term Disability insurance replaces part of your income if the ailment causes you to temporarily be away from work. As long as you remain disabled, you may receive payments for up to three months depending on the plan you choose.

You are generally considered disabled if you are unable to perform important parts of your job—and your income suffers a result.

This insurance covers a variety of conditions and injuries. Some common reasons people use Short Term Disability are:

- Pregnancy*
- Injuries
- Joint disorders
- Back problems
- Digestive issues

* *Pregnancy is covered nine months after coverage becomes effective. Medical complications of pregnancy may be considered as any other covered illness subject to the pre-existing condition limitation.*

**Portability:** You can continue your coverage on a direct-bill basis at the same rates if you leave employment at Hamline.

## PLAN DESCRIPTION

| | BENEFIT OPTIONS |
|---|---|
| Monthly Benefit | $400 to $5,000, up to 60% of your salary |
| Elimination Period<br>The number of days that must pass between your first day of a covered accident or illness and the day you can start receiving disability benefits. | **7/7 or 0/14:**<br>The first number is the elimination period for a covered off-the-job accident. The second number is the elimination period for a covered illness |
| Benefit Duration<br>The number of months you could receive benefits while you are disabled. | 3 months |
| Pre-existing Condition | Benefits for a disability due to a pre-existing condition will not be paid if that disability began within 12 months of your coverage effective date. |

| IMPORTANT NOTE: |
|---|
| **Rates vary based on Age, Monthly Income Range, Monthly Benefit, and Elimination Period.** While enrolling, your rates will be calculated for you based on the parameters that you select. |

# ADDITIONAL BENEFITS

## EMPLOYEE ASSISTANCE PROGRAM – EAP FOR MEDICA MEMBERS

The Employee Assistance Program available through Optum is an excellent source for confidential support, expert information and valuable resources, when you need it the most. You have access 24/7 to master's-level clinicians. Counselors have a wide range of expertise to assist you, including specialty teams for tobacco and gambling problems. Management consultation counselors are also available to help with workplace issues.

When appropriate, Optum will connect you with a local counselor who can address your concerns in person. You have access to five face-to-face visits covered at 100% per issue, per year. If you need additional assistance, the counselors can help you get care through your Medica health plan or refer you to affordable community resources.

For more information or to speak to a clinician, call Optum at 800.626.7944.

## EMPLOYEE ASSISTANCE PROGRAM – EAP THROUGH UNUM

The employee assistance program through Unum (provided by HealthAdvocate) provides employees access to counselors and services for help with personal, family and work issues including stress, depression, anxiety, relationship issues, divorce, job stress, work conflicts, family and parenting problems, anger, grief and loss, addiction, eating disorders and mental illness. The EAP offers 24/7 access to master's level staff clinicians for information, assessment, short-term problem resolution and referrals, and up to 3 (three) face-to-face counseling sessions. In lieu of face to face sessions, HIPAA compliant video counseling sessions are offered for those who prefer the use of technology to receive the service.

Employees may call 1.800.854.1446 (multi-lingual) to be referred to a local counselor. These resources may also be accessed online at **www.unum.com/lifebalance**.

## METLIFE LEGAL PLANS

Metropolitan General Insurance Company (MetGen), a wholly owned subsidiary of MetLife, Inc., provides you with an unlimited number of telephone and office consultations with the attorney of your choice from within the MetGen network. The monthly cost of **$18** covers you, your spouse and dependents. Your premium is automatically deducted from your paycheck on a post-tax basis. Additional services for legal representation and family matters are available at an additional fee.

During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action. Areas of legal consultation include:

- Estate planning
- Family law
- Juvenile matters
- Money matters
- Traffic offenses
- Consumer protection
- Real estate matters
- Document preparation
- Defense of civil lawsuits
- Elder law matters
- Immigration assistance
- Personal property protection

For more information, visit **members.legalplans.com** and enter access code GETLAW. You can also call 800.821.6400.

# ADDITIONAL BENEFITS

## MEDICAL BILL SAVER – THROUGH HEALTHADVOCATE

Hamline University faculty and staff have access to experienced negotiators who can assist with confusing and difficult medical bills. Using fee benchmarking databases to help reduce non-covered medical and dental bills that exceed $400 (regardless of insurance or benefit status), this team will contact doctors, dentists, hospitals and other providers on employees' behalf to negotiate discounts on the balance due and/or create payment plans.

Call **1.800.854.1446** to learn more!

## WILL PREP & LIFE PLANNING SERVICES – THROUGH UNUM EAP

Your Unum EAP benefit includes access to the simple tools needed to create a basic will. The work-life balance website also provides additional information about the following end-of-life topics, which you may wish to consider in drafting your will:

- Estate planning
- Advance directive or living will
- Power of attorney
- Final arrangements memorandum

To access the Personalized Legal Center, visit **www.unum.com/lifebalance**, click "Access Benefits," and select "Legal," or call **1.800.854.1446**.

## TRAVEL ASSISTANCE – THROUGH UNUM

If you are 100 or more miles from home with a medical problem or emergency, this benefit can help you evaluate, troubleshoot and make immediate recommendations for any emergency situation. Issues may range from a lost prescription to hospital admission to the need for medical evacuation. For assistance, call **800.527.0218** or **410.453.6330** and provide them with ID number 322541.

# TERMS DEFINED

**Coinsurance**
Coinsurance is the rate at which you and the plan share expenses. The coinsurance percentages noted in this guide are the covered percentage paid by Medica. For example, 80% coverage indicates 80% of the cost is paid by the plan and it is your responsibility as a participant to pay the remaining 20% of the cost of service. The coinsurance rates vary depending on the medical plan and whether the services are incurred in-network or out-of-network. *(Note: coinsurance shown in other documents may indicate the participant's coinsurance percentage rather than the plan's percentage.)*

**Copay**
The fixed-dollar amount you pay for specific services in Plans C and D. After you pay this amount, the plan pays the rest of the cost of your service or prescription.

**Deductible**
The annual amount you must pay for non-preventive services before the plan starts to pay benefits.

**Embedded Deductible**
The IRS regulates the minimum deductible level at which a high deductible health plan may have an embedded deductible. For 2025, this minimum is $3,300 single / $6,600 family. Plans with an embedded deductible have a single deductible "embedded" within the family deductible to help limit an individual's expenses. This means that if one person in a family meets the single deductible, the plan coinsurance would start. Without an embedded deductible, one person in a family would need to meet the entire family deductible before the plan coinsurance would go into effect.

**Out-of-Pocket Maximum**
For your protection, all plans have annual out-of-pocket maximums that "cap" the amount you must pay toward covered expenses. Once you meet your out-of-pocket maximum, the plan pays 100% of your covered expenses for the rest of the calendar year. Deductibles, copays and coinsurance count toward your out-of-pocket maximum. Out-of-pocket maximums differ for in-network and out-of-network services.

**Pharmacy Formulary**
A list of prescription drugs used by practitioners to identify drugs that offer the greatest overall value. A team of physicians and pharmacists regularly reviews new and existing drugs to be sure the Preferred Drug List continues to meet the needs of members and providers. Drugs may be added to the list at any time during the year; however, Medica strives to limit removing drugs to no more than twice a year.

**Premium**
The amount you pay out of your paycheck toward the cost of coverage.

**Preventive Care**
Routine preventive care is critical to maintaining your health and uncovering problems early. All Hamline medical plans cover certain preventive services at 100% (no deductible or copay) from in-network providers. Services include annual wellness exams and certain screenings based on age for you and your covered dependents.

**Prior Authorization**
Prior Authorization approval is needed by Medica for coverage of a certain medications, services or supplies. Medications that require Prior Authorization are noted on the Preferred Drug List with a "PA" next to the drug name.

**Step Therapy**
Step Therapy is a program focused on using cost-effective prescription drugs as first-line treatment when appropriate. The program is used for certain conditions where there are many treatment options available. Drugs that require Step Therapy are noted on the Preferred Drug List. In Step Therapy, you try the preferred (Step 1) drug or drugs first as they are the most cost effective. If those, don't work then you can try Step 2, and so on.

**Usual and Customary (U&C)**
Payment for health care services received out-of-network is based on the U&C rates. The rate will be used to determine how much will be paid for a specific service. When out-of-network, you are responsible for the difference between what your provider charges and what the plan considers U&C, plus any co-insurance. The amount above and beyond the U&C rate is your responsibility and does not count towards the plan deductible or the out-of-pocket maximums.

# IMPORTANT RESOURCES

| BENEFIT | CONTACT INFORMATION |
|---|---|
| **Medical Insurance**<br>Medica - Group #s vary – see your ID card<br>Networks: Passport, Elect and VantagePlus<br>Member Services: 800.952.3455 | www.Medica.com/SignIn<br>-Access benefit and claim information<br>-Order replacement or temporary cards<br>-Participate in My Health Rewards Programs<br>-Estimate health care and pharmacy costs<br>www.welcometomedica.com/hamline |
| **Dental Insurance**<br>Delta Dental – Group #100475<br>Network: PPO & Premier<br>Member Services: 800.448.3815 | www.deltadentalmn.org<br>-Access benefit and claim information<br>-Locate participating dentists |
| **Vision Insurance**<br>EyeMed – Group #1008703<br>Member Services: 888.203.7437 | www.eyemed.com<br>-Locate participating provider<br>-Print benefit cards |
| **Life Insurance & Long Term Disability**<br>Unum<br>Member Services: 800.858.6843 | www.unum.com/employees<br>-File and track a claim<br>-Review plan information |
| **Health Savings Account (HSA)**<br>Lively<br>1.888.576.837 | www.livelyme.com<br>-Request replacement debit cards<br>-Check account balances<br>-Update Beneficiary Information |
| **Flexible Spending Accounts (FSA)**<br>ThrivePass<br>Flex Account Questions: 866.855.2844<br>tpa@thrivepass.com | app.thrivepass.com<br>- Request replacement debit cards<br>- Check account balances<br>- Submit claims for reimbursement<br>- Sign up for carrier connect for debit card substantiation and claim submission |
| **Short Term Disability, Critical Illness, Hospital Indemnity**<br>Unum<br>Customer Service: 800.635.5597 | www.unum.com/employees<br>-Access policy information<br>-File a claim<br>-See important service contact numbers |
| **Legal Insurance**<br>MetLife Legal Plans<br>Client Services: 800.821.6400 | members.legalplans.com<br>-Locate an attorney<br>-Request a claim number |
| **Retirement**<br>TIAA<br>Client Services: 800.842.2252 | https://www.tiaa.org/public/tcm/hamline<br>-Update Beneficiary Information<br>-Change investment allocations<br>-Check account balances |
| **Employee Assistance Program (EAP)**<br>Unum<br>HealthAdvocate: 1.800.854.1446 | www.unum.com/lifebalance<br>-Available to all Hamline Employees<br>-100% Confidential<br>-Available 24/7 |
| **Employee Assistance Program (EAP)**<br>Medica<br>800.626.7944 | -Available to all Hamline Employees<br>-100% Confidential<br>-Available 24/7 |

Please email the Benefits Administrator at **ccarlson28@hamline.edu** or call **651.523.2815** if you have questions regarding your eligibility or the benefit enrollment process.