UNIVERSITY OF NEW ENGLAND

2024 Benefits Guide

UNE

UNIVERSITY OF NEW ENGLAND

INNOVATION FOR A HEALTHIER PLANET

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Welcome to Your 2024 Benefits Package

UNE is committed to providing a competitive and comprehensive benefits package that provides you with several options, enabling you to select the benefits that are best suited for you and your family. The benefits package is designed to help you stay well, both physically and financially, and provide support and financial protection if the need arises.

The benefits package includes group Medical, Dental, Vision, Life, and Disability insurance coverage. Health Savings Account funds, tax-advantaged Flexible Spending Accounts, and a 403(b) Retirement Plan are also offered.

UNE provides a Wellness Program to all benefits-eligible employees, offering opportunities for employees to learn, practice, and be rewarded for healthy habits. You also have access to Health Advocate and an Employee Assistance Program, both free and confidential resources designed to help support you and your family.

In an effort to support your personal circumstances, a variety of voluntary insurance products are offered through payroll deductions. Details on each of these programs are outlined within this guide.

For additional information please contact your Human Resources Department at (207) 602-2283 or email Human Resources at hr@une.edu.

Important Information for 2024

Health Plan

Cigna is our new Health Plan Provider

The deductibles and out-of-pocket costs for the Basic and Enhanced plans remain the same for 2024.

Due to IRS regulations, the deductible for the HDHP with HSA ("HSA") plan did increase to $3,200 for individual coverage and $6,400 for family coverage, which is now equivalent to the annual out-of-pocket maximum.

The HDHP w/HSA medical plan will no longer have referral requirements, providing you with greater flexibility and ease of access to health care. You also are no longer required to select a PCP in Cigna's online portal, ***though it is recommended.***

Cigna now offers enhanced infertility treatment coverage, including an exciting incentive for early sign-ups to their Healthy Pregnancies, Healthy Babies program.

Cigna does not issue physical insurance cards. You can access digital ID cards anytime after January 1, 2024, by registering online at my.cigna.com.

Health Savings Account (HSA)

We are switching from Benefit Wallet to HSA Bank as the administrator of HSA bank accounts, which promises increased support and resources for both employees and HR.

In 2024, if you elect the HSA medical plan all contributions (including UNE's) must be made to your new HSA Bank account. HR will be sharing important details following the conclusion of Open Enrollment regarding action steps that will be needed in order to transfer your current funds from BenefitWallet to HSA Bank.

UNE will continue to make contributions to eligible employees' HSA accounts on a per pay basis, contributing up to $2,600 annually. In addition to UNE's contribution, you can also make pre-tax contributions on a per pay period basis. The IRS has increased annual contribution limits permitted for 2024. If you elect employee only coverage, you are permitted to contribute up to $4,150. If you elect employee + dependent coverage (Employee/Child, Employee/Spouse or Family), you are permitted to contribute up to $8,300. Employees who are at least 55 years of age at any point in 2024 can deposit an additional $1,000. These totals include money from all sources, which means the deposits UNE makes to your account accumulate toward the maximums.

Important Information for 2024

Summary of Benefits and Coverage (SBC) and Summary of Plan Description (SPD)

The Summary of Benefits and Coverage (SBC) and Summary of Plan Description (SPD) documents for all benefits-eligible employees are located on our Human Resources website at www.une.edu/hr/benefits/health-benefits. These documents provide standard coverage information of the three medical plans through Cigna. The Summary of Benefits and Coverage is also available in paper form free of charge upon request. If you'd like a printed copy or have any coverage questions, please reach out to Human Resources and we'd be happy to assist you.

Vision Benefits

Separate Voluntary Vision Coverage

Vision insurance is no longer automatically included with one of the three medical insurance plans. Our vision coverage will be through Cigna Vision. You now have the option to elect vision coverage separately from medical insurance, providing you with more flexibility in your benefit choices.

Note: The Cigna medical plan will only cover one's annual vision exam.

Short Term Disability

We are excited to announce that Short Term Disability rates have decreased for 2024, and there has been an adjustment in age brackets to now include "70-74" and "75+" options. The benefit continues to be offered through The Standard.

Your salary (and Benefit election) is locked in as of January 1st unless you experience an employment status change.

Life Insurance

If you elect coverage greater than $350,000 or choose to increase your elected amount (such as going from 1x to 2x coverage), you will need to complete an Evidence of Insurability (EOI) form, which you may obtain through HR or The Standard.

If you are 70+ years of age, or will be turning 70 in 2024, please speak with HR to discuss how your coverage may be affected in 2024.

Retirement

Enhanced 403(b) Retirement Plan Feature

Effective January 2024, UNE will be providing the employer match for both pre-tax and Roth (post-tax) employee contributions, up to a combined match limit of 8%, to the Fidelity 403(b) retirement plan. This change will provide you with more options for your retirement planning. Additional details will be provided by HR in the coming weeks.

Important Information for 2024

Flexible Spending Account (FSA)

UNE has increased the medical FSA limit from $2,850 to $3,050 and will continue to offer the Dependent Care FSA. The maximum for the Dependent FSA will remain $5,000.

Employee Assistance Program (EAP)

UNE's Employee Assistance Program continues to be offered by Health Advocate in connection with Standard Insurance Company. This benefit is available to all employees, their spouses, and dependents (children up to age 26). The offering includes up to six face-to-face counseling sessions per issue. It also provides work/life resources such as child care, adult care, legal assistance, and financial assistance. You may reach out for services by calling 877-851-1631 or by going to Healthadvocate.com/standard6. Assistance is available 24 hours a day, 7 days a week.

Domestic Partners

Domestic partners may be added to your medical, vision, and/or dental insurance plans if you meet specific requirements and complete a domestic partner affidavit with Human Resources. By adding a domestic partner to your plan(s), you will be charged the associated premium and will be taxed on that benefit ("imputed tax liability").

About Your Benefits

Eligibility Information

Benefits-eligible employees may elect Medical, Vision, and/or Dental coverage for themselves and their eligible dependents. If you are a full-time benefits-eligible employee you will automatically be enrolled in UNE's Basic Life, AD&D, and Long Term Disability policies. All benefit-eligible employees have the option to purchase Supplemental Life and Short Term Disability. Children can be covered as dependents on your Medical, Dental and Vision plans until age 26, regardless of student status. Domestic partners may be added to your medical, vision, and/or dental insurance plans if you meet specific requirements and complete a domestic partner affidavit with Human Resources. By adding a domestic partner to your plan(s), you will be charged the associated premium and will be taxed on that benefit ("imputed tax liability").

When Coverage Begins and Ends

Coverage for eligible new hires begins on the first of the month following your date of hire. If you enroll in benefits during UNE's Open Enrollment period, coverage will begin on January 1st. Coverage for Medical, Dental, and Vision benefits end on the last day of the month following termination from UNE. All other benefits end on your last day of employment.

Making Changes During the Year

Generally, you can only change your benefit elections during the Open Enrollment period, unless you experience a qualifying life event such as marriage, divorce, birth or adoption, or a change in your or your spouse's employment status that affects benefits eligibility. You must notify HR within 30 days of a qualifying life event.

Please note: If a Domestic Partner is covered on your medical, vision, and/or dental insurance plan(s) and your status changes (such as marriage or separation), please contact HR within 30 days.

COBRA: Continuing Coverage After Termination

Under most circumstances, you and your dependents may continue to participate in select benefit plans through COBRA Insurance after you terminate employment. You will be advised of your COBRA rights if you experience a COBRA qualifying event. For more information contact Flores247 at 800-532-3327.

Section 125 Plan Benefit

A Section 125 Plan is an IRS-regulated benefit that allows an employee to make certain benefit contributions on a pre-tax, rather than a post-tax, basis. Such plans permit Medical, Health Savings Account (HSA), Dental, Vision, and FSA contributions by employees to be deducted from earnings before taxes are calculated. Employees who are eligible and participate in UNE's plans will automatically receive this benefit.

Evidence of Insurability (EOI)

If you are electing supplemental life insurance coverage for the first time, and were previously eligible, you will have to complete an Evidence of Insurability form for any amount of coverage you elect now or in the future.

If you elect coverage greater than $350,000 or choose to increase your elected amount (such as going from 1x to 2x coverage), you will need to complete an Evidence of Insurability (EOI) form, which you may obtain through HR or The Standard. For this purpose, UNE's group name is University of New England and the group number is 144362-A.

If the initial EOI for a salary increase is approved, you will not have to show EOI for any additional salary increases in the future.

If the initial EOI for an increased plan election is approved, and in the future you make additional increases such as going from 2x to 3x coverage, you will be required to complete the EOI process again for that increased election. Your newly elected increased level of coverage will not go into effect until this form is completed and approved by The Standard.

Failure to complete the EOI may affect your benefit.

If you are 70+ years of age, or will be turning 70 in 2024, please speak with HR to discuss how your coverage may be affected in 2024.

Medical Benefits

Think Healthy. Live Well. There's nothing more valuable than your good health! UNE offers a choice of medical plans that are designed to help you and your family stay healthy and to provide comprehensive coverage when you need it.

Cigna Medical Plans

UNE offers a choice of three medical plans through Cigna. More information about Cigna, including a list of in-network providers, may be obtained by visiting the Cigna webpage (www.Cigna.com).

Highlights of the Cigna medical plans include:

- In-Network Preventive Care services covered 100%
- Access to a Cigna Customer Service Representative via toll free number
- Online access to view your personal claim history, account transactions, plan coverage, claim forms, and more
- Cost and quality provider directory to help you compare doctors and medical procedures to control your health care spending
- Emergency and Urgent Care when you need it anywhere worldwide
- 24-hour online urgent care through your plan with copay

For 2024, the HDHP w/HSA health plan no longer requires you to select a Primary Care Provider (PCP) or obtain a referral to see specialists.

Basic

Employee coinsurance is 20% after $500 individual/$1,000 family deductible has been met. Under this plan, office visits require you to pay a $25 co-payment when you see your in-network Primary Care Physician or an in-network specialist. Some provider services may be subject to a plan deductible. No referral requirement for specialist care is needed. Prescription drugs require a co-payment. One co-payment is required when you obtain a 30-day supply of prescription drugs. Two co-payments are required for 31 to 90 day supply for both retail and mail order prescription drugs. The co-payment for prescriptions is $15 for generic drugs, $30 for preferred name brand drugs, and $50 for non-preferred name brand drugs.

Enhanced

$500 individual/$1,000 family deductible and 0% (zero) employee coinsurance once deductible has been met. Under this plan, office visits require you to pay a $20 co-payment when you see your in-network Primary Care Physician or an in-network specialist. No referral requirement for specialist care is needed. Some provider services may be subject to a plan deductible. Prescription drugs require a co-payment. One co-payment is required when you obtain a 30-day supply of prescription drugs. Two co-payments are required for 31 to 90 day supply for both retail and mail order prescription drugs. The co-payment for prescriptions is $10 for generic drugs, $20 for preferred name brand drugs, and $35 for non-preferred name brand drugs.

High Deductible Health Plan with Health Savings Account (HSA)

10% in-network, 30% out-of-network employee coinsurance; $3,200/$6,400 deductible. Under this plan, all covered medical and prescription drug expenses accumulate toward the deductible. Specified preventive prescription drugs are covered in full.

- Cigna's Preventive Plus Package applies to the HSA plan only. Both the deductible and the cost share is waived for generic and preferred brand drugs. For non-preferred brand drugs, only the deductible is waived.
- The Basic and Enhanced plan waive the deductible and cost share for just **diabetic supplies and CGMs only (for generic and preferred brands).**
- Additionally, under ACA there are drugs available under this plan at no cost share.

High Deductible Health Plan with Health Savings Account (HSA) Cont.

The High Deductible Health Plan associated with the Health Savings Account (HSA) is an open access plus plan offering you flexibility for your health care needs. You no longer need a referral to seek care from a specialist. For eligible participating employees in 2024, UNE will provide the employer HSA contribution on a per pay period basis. UNE will continue to contribute up to $2,600 annually to an eligible participating employee's HSA account.

- If electing the High Deductible Health Plan with a Health Savings Account ("HSA" Plan), please be aware that through the Patriot Act you may be chosen to verify some of your personal information. You will receive a letter in the mail from HSA Bank informing you of what is needed to establish your health savings account. Please act promptly. You will receive 3 letters in a 90 day period to request the verification of the needed information. If you do not send the information the account will close and you will forego the UNE contributions until the point the account is fully opened. Also any funds in the account that has not yet been successfully opened will be returned to you. You may contact HSA Bank with any questions regarding this verification process by calling them at 800-357-6246.
- If you do not open your health savings account and terminate employment prior to doing so, you will forfeit all UNE employer contributions to your health savings account.
- Important reminder: IRS regulations do not allow for health savings account funds to be used for eligible expenses that are inccured prior to one's health savings account being successfully opened.

In addition to the deposits made by UNE associated with your health coverage, you can also contribute your own pre-tax funds into this plan, and you can change your contribution amount at any time during the year. Under IRS rules, the maximum that can be deposited into your HSA in 2024 is $4,150 if you have employee only coverage or $8,300 if you have family coverage. Employees who are at least 55 years of age at any point in 2024 can deposit an additional $1,000. These totals include money from all sources, which means the deposits UNE makes to your account accumulate toward the maximums. **If you have a health savings account, you cannot have other coverage, including Medicare Part A.**

IMPORTANT NOTE RELATING TO HSA & MEDICARE: If you elect the HSA medical insurance plan and decide to enroll in Medicare after delaying your enrollment, you should stop contributing to your HSA (including UNE's employer contributions) at least six months in advance of enrolling in Medicare. Otherwise, you may incur a tax penalty because Part A of Medicare provides six months of retroactive coverage upon enrollment. You should contact a UNE Human Resources representative at least six months in advance to complete the necessary paperwork to stop HSA contributions.

The many benefits to maintaining a Health Savings Account include:

- **Control** – You can use the HSA to pay for any qualified medical expenses.
- **Flexibility** – Your HSA dollars can pay for items identified under your health insurance plan, but also can encompass a broader definition as defined by the IRS which includes dental, vision, orthodontia, and more.
- **Portability** – You can take your HSA funds with you; the account belongs to you.
- **Tax Savings** – Your contributions to the HSA are made with pre-tax dollars.
- **Not Subject to "Use-it-or-lose-it"** – Balances roll from year to year.

HSA AUTOMATIC ACCOUNT OPENING

If you elect the qualified High Deductible Health Plan (HDHP) with a Health Savings Account ("HSA" Plan) option through UNE's Internal Revenue Code Section 125 Cafeteria Plan, UNE will provide HSA Bank with data and information both requested and reasonably needed by HSA Bank in order to open your HSA. This includes acceptance of the HSA Bank terms, conditions, rate, and fee schedule on your behalf, as well as agreeing to receive account statements and other account documents electronically.

Medical Plans At-a-Glance

	Basic		Enhanced		HDHP w/HSA	
Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$500 Individual $1,000 Family		$500 Individual $1,000 Family		$3,200 Individual $6,400 Family	
Annual Out-of-Pocket Maximum	$3,500 Individual $7,000 Family		$3,000 Individual $6,000 Family		$3,200 Individual $6,400 Family	$6,400 Individual $12,800 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Services	No Charge	Deductible then 40%	No Charge	Deductible then 20%	No Charge	Deductible then 30%
Routine Mammograms	No Charge	Deductible then 40%	No Charge	Deductible then 20%	No Charge	Deductible then 30%
Primary Care Visit	$25 Copay	Deductible then 40%	$20 Copay	Deductible then 20%	Deductible	Deductible then 30%
Specialist Visit*	$25 Copay	Deductible then 40%	$20 Copay	Deductible then 20%	Deductible	Deductible then 30%
Chiropractic Services	$25 Copay	Deductible then 40%	$20 Copay	Deductible then 20%	Deductible	Deductible then 30%
Outpatient Services (Diagnostic/X-ray/ Lab Services)	Deductible then 20%	Deductible then 40%	Deductible only	Deductible then 20%	Deductible	Deductible then 30%
Outpatient Complex Services (MRI, CAT, PET Scans, etc.)	Deductible then 20%	Deductible then 40%	Deductible only	Deductible then 20%	Deductible	Deductible then 30%
Inpatient Hospital Services	Deductible then 20%	Deductible then 40%	Deductible only	Deductible then 20%	Deductible	Deductible then 30%
Outpatient Surgery	Deductible then 20%	Deductible then 40%	Deductible only	Deductible then 20%	Deductible	Deductible then 30%
Emergency Room (waived if admitted)	$150 Copay	$150 Copay	$100 Copay	$100 Copay	Deductible then 10%	Deductible then 10%
Outpatient Mental Health Benefits	$25 Copay	Deductible then 40%	$20 Copay	Deductible then 20%	Deductible	Deductible then 30%
Inpatient Mental Health Benefits	Deductible then 20%	Deductible then 40%	Deductible only	Deductible then 20%	Deductible	Deductible then 30%
Annual Routine Vision Exam	No Charge	No Charge	No Charge	No Charge	100% after Deductible	100% after Deductible
Pharmacy Benefit Note: If you fill a prescription at an Out of Network pharmacy, you will be required to pay for the script and request reimbursement through Express Scripts.	Retail $15/$30/$50 Home Delivery $30/$60/$100	You pay 20% Plan pays 80%	Retail $10/$20/$35 Home Delivery $20/$40/$70	You pay 20% Plan pays 80%	Retail / Home Delivery - Deductible then 10%	Retail Only - Deductible then 30%

Monthly Medical Plan Premium Contributions

Monthly Cost for 12 Month Faculty/Professional Staff

	Full-Time 12 Month Paid			Half-Time 12 Month Paid		
	Basic	Enhanced	HDHP w/ HSA	Basic	Enhanced	HDHP w/ HSA
Single Person Coverage	$104.58	$263.74	$72.82	$155.96	$584.22	$100.00
One parent & Child/ren Coverage	$261.72	$447.32	$180.14	$789.16	$1,066.22	$619.86
Two Adult Coverage	$462.62	$716.50	$351.42	$1,099.72	$1,440.22	$881.44
Family Coverage	$473.20	$804.36	$375.70	$1,212.92	$1,616.30	$991.70

Monthly Cost for 11 Month Faculty/Professional Staff

	Full-Time 11 Month Paid			Half-Time 11 Month Paid		
	Basic	Enhanced	HDHP w/ HSA	Basic	Enhanced	HDHP w/ HSA
Single Person Coverage	$114.08	$287.72	$79.44	$170.16	$637.32	$116.46
One parent & Child/ren Coverage	$285.52	$488.00	$196.52	$860.90	$1,163.14	$676.20
Two Adult Coverage	$504.68	$781.62	$383.36	$1,199.70	$1,571.12	$961.56
Family Coverage	$516.24	$877.48	$409.86	$1,323.16	$1,763.22	$1,081.86

Monthly Cost for 10 Month Faculty/Professional Staff

	Full-Time 10 Month Paid			Half-Time 10 Month Paid		
	Basic	Enhanced	HDHP w/ HSA	Basic	Enhanced	HDHP w/ HSA
Single Person Coverage	$125.50	$316.48	$87.38	$187.16	$701.06	$128.10
One parent & Child/ren Coverage	$314.06	$536.78	$216.16	$946.98	$1,279.48	$743.82
Two Adult Coverage	$555.16	$859.82	$421.70	$1,319.68	$1,728.28	$1,057.72
Family Coverage	$567.86	$965.22	$450.86	$1,455.50	$1,939.54	$1,190.04

Monthly Cost for 9 Month Faculty/Professional Staff

	Full-Time 9 Month Paid			Half-Time 9 Month Paid		
	Basic	Enhanced	HDHP w/ HSA	Basic	Enhanced	HDHP w/ HSA
Single Person Coverage	$139.44	$351.66	$97.08	$207.94	$778.96	$142.34
One parent & Child/ren Coverage	$348.94	$596.44	$240.18	$1,052.20	$1,421.78	$826.46
Two Adult Coverage	$616.86	$955.34	$468.56	$1,466.32	$1,920.30	$1,175.24
Family Coverage	$630.94	$1,072.46	$500.96	$1,617.22	$2,155.04	$1,322.26

NOTE: Domestic partners may be added to your medical, vision, and/or dental insurance plans. By adding a domestic partner to your plan(s), you will be charged the associated premium and will be taxed on that benefit ("imputed tax liability").

Vision Benefits

Vision insurance is no longer automatically included with one of the three medical insurance plans. You now have the option to elect Cigna Vision coverage seperately from medical insurance, providing you with more flexibility in your benefit choices.

NOTE: The Basic and Enhanced health plans will only cover one's annual routine eye exam. The HSA health plan also covers one's annual routine eye exam, which is subject to the deductible and then the plan will pay at 100%.

You can look up network providers using https://eyedoclocator.eyemedvisioncare.com/cigna/en.

Coverage	Eye Med Network	
	In-Network (Copay)	**Out-of-Network (Before Copay)**
Exam Copay	$25	$45 max
Exam Allowance (one per frequency, no age limit)	Calendar Year	
Base Lenses: (Every other calendar year)		
Single Vision Allowance	$25	$32 max
Bifocal Allowance	$25	$55 max
Trifocal Allowance	$25	$65 max
Lenticular	$25	$65 max
Frame Retail Allowance (every other year)	$130 retail max + 20% off balance	$71 max
Contact Lenses Benefits (In lieu of eyeglass lenses and/or frames)		
Medically Necessary	$0	$210 max
Elective Materials	$130 max (copay waived)	$100 max (copay waived)
Elective Fitting and Evaluation	Included in the Contact Lens Allowance.	Included in the Contact Lens Allowance.

Monthly Vision Plan Contributions

Monthly Vision Cost for 12 Month Faculty/Professional Staff

	Full-Time and Half-Time 12 Month Paid
	Eye Med
Single Person Coverage	$2.22
One parent & Child/ren Coverage	$4.48
Two Adult Coverage	$4.44
Family Coverage	$7.16

Monthly Vision Cost for 11 Month Faculty/Professional Staff

	Full-Time and Half-Time 11 Month Paid
	Eye Med
Single Person Coverage	$2.42
One parent & Child/ren Coverage	$4.88
Two Adult Coverage	$4.84
Family Coverage	$7.80

Monthly Vision Cost for 10 Month Faculty/Professional Staff

	Full-Time and Half-Time 10 Month Paid
	Eye Med
Single Person Coverage	$2.66
One parent & Child/ren Coverage	$5.38
Two Adult Coverage	$5.32
Family Coverage	$8.58

Monthly Vision Cost for 9 Month Faculty/Professional Staff

	Full-Time and Half-Time 9 Month Paid
	Eye Med
Single Person Coverage	$2.96
One parent & Child/ren Coverage	$5.98
Two Adult Coverage	$5.92
Family Coverage	$9.54

NOTE: Domestic partners may be added to your medical, vision, and/or dental insurance plans. By adding a domestic partner to your plan(s), you will be charged the associated premium and will be taxed on that benefit ("imputed tax liability").

Dental Benefits

You have the ability to purchase dental insurance benefits on a pre-tax basis. UNE provides the option to choose between two dental plans through Northeast Delta Dental so that you can elect a plan that works best for you and your family.

More information about Delta Dental, including a list of in-network participating providers, may be obtained by visiting the Delta Dental webpage (www.nedelta.com).

	Northeast Delta Dental Basic Option*	Northeast Delta Dental Enhanced Option*
Annual Deductible	$25 / $75 Deductible Per Person/ Family Per Calendar Year Deductible applies to Basic Restorative and Major Restorative Services	$25 / $75 Deductible Per Person/ Family Per Calendar Year Deductible applies to Basic Restorative and Major Restorative Services
Annual Benefit Maximum	$1,000 Calendar Year Maximum	$1,500 Calendar Year Maximum
Diagnostic & Prevention Services	Deductible Waived Plan pays 80%	Deductible Waived Plan pays 100%
Basic Restorative Services	Deductible then plan pays 50%	Deductible then plan pays 80%
Major Restorative Services	Deductible then plan pays 50%	Deductible then plan pays 50%

** The cost share for these services is based on your use of a Delta Dental in-network participating provider. If you visit an out of network dentist, you may be required to submit your own claim and pay for services at the time they are provided. Payment to out of network dentists will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for out of network dentists in the geographic area in which services are provided.*

Please note: Services are based on a rolling 12-month period, not a calendar year period. For example: diagnostic/ preventive evaluations are covered twice in a rolling 12-month period.

Monthly Dental Plan Contributions

Monthly Dental Cost for 12 Month Faculty/Professional Staff

	Full-Time 12 Month Paid		Half-Time 12 Month Paid	
	Northeast Delta Dental Basic Option	Northeast Delta Dental Enhanced Option	Northeast Delta Dental Basic Option	Northeast Delta Dental Enhanced Option
Single Person Coverage	$4.70	$19.14	$16.32	$30.76
One parent & Child/ren Coverage	$28.54	$54.06	$40.16	$65.70
Two Adult Coverage	$46.92	$81.00	$58.56	$92.62
Family Coverage	$56.42	$97.30	$64.66	$108.94

Monthly Dental Cost for 11 Month Faculty/Professional Staff

	Full-Time 11 Month Paid		Half-Time 11 Month Paid	
	Northeast Delta Dental Basic Option	**Northeast Delta Dental Enhanced Option**	**Northeast Delta Dental Basic Option**	**Northeast Delta Dental Enhanced Option**
Single Person Coverage	$5.12	$20.90	$17.82	$33.56
One parent & Child/ren Coverage	$31.16	$59.02	$43.82	$71.70
Two Adult Coverage	$51.22	$88.34	$63.86	$101.04
Family Coverage	$61.54	$106.16	$70.52	$118.82

Monthly Dental Cost for 10 Month Faculty/Professional Staff

	Full-Time 10 Month Paid		Half-Time 10 Month Paid	
	Northeast Delta Dental Basic Option	**Northeast Delta Dental Enhanced Option**	**Northeast Delta Dental Basic Option**	**Northeast Delta Dental Enhanced Option**
Single Person Coverage	$5.64	$22.94	$19.60	$36.90
One parent & Child/ren Coverage	$34.24	$64.90	$48.16	$78.84
Two Adult Coverage	$56.32	$97.20	$70.24	$111.14
Family Coverage	$67.68	$116.78	$77.60	$130.72

Monthly Dental Cost for 9 Month Faculty/Professional Staff

	Full-Time 9 Month Paid		Half-Time 9 Month Paid	
	Northeast Delta Dental Basic Option	**Northeast Delta Dental Enhanced Option**	**Northeast Delta Dental Basic Option**	**Northeast Delta Dental Enhanced Option**
Single Person Coverage	$6.22	$25.48	$21.76	$41.00
One parent & Child/ren Coverage	$38.08	$72.12	$53.54	$87.60
Two Adult Coverage	$62.58	$108.04	$78.08	$123.50
Family Coverage	$75.20	$129.72	$86.18	$145.22

NOTE: Domestic partners may be added to your medical, vision, and/or dental insurance plans. By adding a domestic partner to your plan(s), you will be charged the associated premium and will be taxed on that benefit ("imputed tax liability").

Flexible Spending Accounts (FSAs)

A Smart Way to Save. With a Flexible Spending Account (FSA), you can set aside pre-tax dollars through payroll deductions to pay for certain health care and dependent care expenses. Plus, you can reduce your tax obligations.

Lower Your Taxes with FSAs

Each year during Open Enrollment, benefits-eligible employees have the option of enrolling in one or both of the following:

- **Health Care FSA** – You can contribute between $250 - $3,050 per year to pay for eligible out-of-pocket health care expenses.
- **Dependent Care FSA** – You can contribute between $250 - $5,000 per year to pay for eligible out-of-pocket dependent care expenses. Typically available for dependent children up through age 12.

End result: You pay less tax on a smaller amount of income and get to keep more take-home pay!

How FSAs Work

Your contributions will be deducted from your paychecks in equal amounts during the plan year.

As you pay for eligible expenses out of your own pocket, you are reimbursed from your account(s).

Money cannot be transferred between accounts for expense reimbursements.

You cannot stop or change your FSA contributions during the plan year unless you have a qualified life event. You must re-enroll in any FSA each year during the annual Open Enrollment period. Per IRS Regulations, funds not spent by the end of the grace period will be forfeited.

For more detailed information about eligible expenses, please check the Flexible Spending Account website at www.flores247.com or call Flores247 directly at 800-532-3327.

FSA Decision Guidelines

Before participating in an FSA, ask yourself questions such as:

- How much were my out-of-pocket health care and dependent care expenses last year?
- Do I expect to pay for some health care costs that are not totally covered by my benefits?

Please note that you cannot elect a medical FSA if you are on the medical HDHP/HSA plan.

"GRACE PERIOD"

PLEASE NOTE: Page 3 of this booklet contains specific IRS regulations for the 2024 plan year.

Regulations allow employers who sponsor FSAs the opportunity to add an extension of time at the end of the plan year during which employees may incur eligible expenses and be reimbursed from their FSA funds. This extension of time is called a "grace period." The University of New England has chosen to add a 2.5 month "grace period" to the 2024 plan year.

The "grace period" allows you the opportunity to spend your 2024 Medical/Dependent Care Flexible Spending Account funds up until March 15, 2025. You have until May 30, 2025 to submit any claims incurred during the plan year or during the "grace period."

If you terminate employment at UNE during 2024, you have until May 30, 2025 to submit for reimbursement. You may only submit for expenses incurred up through your termination date (unless you elect COBRA for your FSA).

Disability Insurance

Disability insurance can provide a sense of security, knowing that if the unexpected should happen, you can still provide for yourself and your family.

The Standard is UNE's Life and Disability insurance carrier. The Standard offers employees the ability to file a claim with one phone call.

Long Term Disability (LTD) Insurance

Full-time benefits-eligible employees will be automatically enrolled in Long Term Disability on the first day of the month following their date of hire.

This benefit assures eligible employees 50% of their income ($7,500/month maximum) in the event that they are disabled for more than 180 days up to the normal Social Security retirement age based upon the Benefit Table in the Long Term Disability Summary Plan Document.

The premium cost for this benefit is paid by the employee on a post-tax basis. However, UNE provides the employee with income to cover this premium cost. Therefore, UNE actually provides this coverage to full-time employees at virtually no cost. In the event of disability, you will not be taxed on any LTD benefit payments.

Short Term Disability (STD) Insurance

Short Term Disability provides income when benefits-eligible employees are absent from work due to a non-occupational illness, injury, or pregnancy related disability. When disabled, benefits typically begin following a 14-day elimination period. The STD benefit replaces a portion of your weekly income, providing funds directly to you. The premium cost for this benefit is paid by the employee on a post-tax basis. In the event of disability, you will not be taxed on any STD benefit payments.

STD coverage is available in $50 increments up to a maximum of 70% of your predictable earnings, with a maximum weekly benefit of $750. The maximum benefit period is 180 days. Your salary (and Benefit election) is locked in as of January 1st, unless you experience a status change.

Short Term Disability rates are calculated based on age in increments of 5 years. The bracket is based on your age as of January 1 each plan year. If you have entered into a new age bracket due to a birthday, your premiums will automatically increase.

Employee's Age as of 1/1/24:	Monthly Cost per $10 of benefit:
Under 30	$0.335
30-34	$0.335
35-39	$0.335
40-44	$0.335
45-49	$0.317
50-54	$0.407
55-59	$0.366
60-64	$0.531
65-69	$0.622
70 -74	$0.812
75+	$0.815

IMPORTANT: If you sign up for Short Term Disability for the first time during Open Enrollment and you become disabled during the first 12 months due to physical disease, mental disorder, or pregnancy, you will have a 60 day elimination period (instead of the regular 14 day elimination period if you sign up during your date of hire).

Life and Accidental Death & Dismemberment Insurance

Life Insurance

If you are a full-time benefits-eligible employee, UNE will automatically provide Group Life Insurance coverage (which includes Accidental Death & Dismemberment coverage) to you at no cost through The Standard. Coverage is equivalent to one times your annual base salary, rounded to the next higher $1,000. UNE also provides a $2.50 monthly credit to use to purchase additional life insurance, pay toward other benefits, or take in cash. The maximum coverage amount is $300,000 and the minimum is $20,000.

Half-time employees do not receive the annual base salary core coverage or the $2.50 per month credit. However, half-time employees may purchase basic life insurance in multiples of 1-4 times their annual salary.

Voluntary Life Insurance

UNE offers additional Life Insurance to be purchased through The Standard. You may purchase this in increments of 1, 2, 3, or 4 times your annual salary, up to $350,000 with no evidence of insurability necessary. For example:

Full-Time Employee Purchased		UNE Provided	=	Total Coverage
1 x Annual Salary	+	1 x Annual Salary	=	2 x Annual Salary
2 x Annual Salary	+	1 x Annual Salary	=	3 x Annual Salary
Half-Time Employee Purchased			=	**Total Coverage**
1 x Annual Salary			=	1 x Annual Salary
2 x Annual Salary			=	2 x Annual Salary

Life insurance rates are calculated based on age in increments of 5 years. The bracket is based on your age as of January 1 each year. If you have entered into a new age bracket due to a birthday, your premiums will automatically increase.

IMPORTANT: If you are electing coverage for the first time, and were previously eligible, you will have to complete an Evidence of Insurability form for any amount of coverage you elect now or in the future.

Life Insurance Rates

Employee's Age as of 1/1/24:	Monthly Cost per $1,000:
Under 30	$0.048
30-34	$0.056
35-39	$0.056
40-44	$0.096
45-49	$0.140
50-54	$0.220
55-59	$0.420
60-64	$0.656
65-69	$1.008
70+	$2.050

EXAMPLE: If your annual salary is $20,000 and you are 36 years old, and you wish to purchase your salary equivalent in life insurance, you would buy $20,000 in life insurance at $0.056 per thousand per month, or $1.12 per month. If you want twice your salary equivalent in insurance, you would need to buy $40,000 at $0.056 per thousand, or $2.24.

If you elect coverage greater than $350,000 or choose to increase your elected amount (such as going from 1x to 2x coverage), you will need to complete an Evidence of Insurability (EOI) form, which you may obtain through HR or The Standard. For this purpose, UNE's group name is University of New England and the group number is 144362-A. If the initial EOI for a salary increase is approved, you will not have to show EOI for any additional salary increases in the future. If the initial EOI for an increased plan election is approved, and in the future you make additional increases such, as going from 2x to 3x coverage, you will be required to complete the EOI process again for that increased election. Your newly elected increased level of coverage will not go into effect until this form is completed and approved by The Standard. Failure to complete the EOI may affect your benefit. If you are 70+ years of age, or will be turning 70 in 2024, please speak with HR to discuss how your coverage may be affected in 2024.

Accidental Death & Dismemberment Insurance

If you are a full-time benefits-eligible employee, UNE will automatically provide Group Life Insurance coverage which includes Accidental Death & Dismemberment coverage to you at no cost through The Standard. Coverage is equivalent to one times annual base salary, rounded to the next higher $1,000.

Wellness Program

A strong organization cannot exist without healthy employees. The choices we make in our everyday lives can help lead us to being healthier and happier. UNE offers a comprehensive wellness program as part of our overall benefit package.

Our Wellness Program is open to all benefits-eligible employees and offers a variety of tools to support a healthy lifestyle and encourage employees to be physically and mentally healthy and happy!

Wellness Rewards Program

Active benefits-eligible employees who elect Cigna medical insurance through UNE may participate in the Wellness Rewards Program. This program is offered to assist in rewarding employees for taking positive preventive measures over their health.

You have the ability to earn rewards if you take certain preventive measures such as:

- Having an annual physical exam - you will earn $50 gift card.
- Speaking with a maternity nurse starting in your first trimester and after your baby is born (Healthy Pregnancies, Healthy Babies program) - you will earn a $100 gift card.
- Speaking with a maternity nurse starting in your second trimester and after your baby is born (Healthy Pregnancies, Healthy Babies program) - you will earn a $50 gift card.

Please visit the Human Resources Wellness website for more information.

NOTE: The annual physical exam is available to employees only. The Healthy Pregnancies, Health Babies incentive is available to employees, spouses, and domestic partners (if the spouse/domestic partner is covered on the employee's Cigna medical insurance plan).

To get started, visit www.mycigna.com, then click on "Wellness" or "View My Incentives." You can also find information by downloading the MyCigna App from your mobile device.

Recreation Center

Eligible University employees have access, at no cost, to the University's athletic complex (weight training, swimming pool, indoor running track, gymnasium, etc). Guests may access UNE Recreation Centers at no cost on Friday evening, Saturday, and Sunday, when accompanied by the employee. UNE provides other wellness opportunities throughout the year, including fitness classes, wellness fairs, an annual Fun Run/Walk, and much more. Please visit the Human Resources website for more information.

Health Advocate

Health Advocate is a service provided by UNE at no cost to you. This service is available to all benefits-eligible employees and your eligible family members. With this service you have confidential, unlimited access to a Personal Health Advocate who can help you resolve health care and insurance related issues through a single toll free number.

The Health Advocate service is centered on a team of Personal Health Advocates, typically registered nurses, supported by medical directors and benefits and claims specialists. The highly personalized services range from addressing a host of health care and insurance-related issues to providing one-on-one support for improving health and well-being. Coverage extends to the employee, spouse or domestic partner, dependent children, parents, and parents-in-law.

How Health Advocate Helps

- Find qualified doctors, dentists, hospitals, and other health care providers anywhere in the country.
- Expedite appointments including those with hard-to-reach specialists.
- Arrange for specialized treatments and tests.
- Provide comparative health cost estimates.
- Help resolve insurance claims.
- Negotiate billing and payment arrangements.
- Assist with eldercare such as finding adult daycare, assisted living and other related issues facing parents and parents-in-law.
- Work with insurance companies to obtain appropriate approvals for needed services.
- Obtain unbiased health information about complex medical conditions to help make informed decisions.
- Answer questions about test results, treatments, and medication prescribed by the physician.
- Assist in the transfer of medical records, x-rays, and lab results.
- Locate and research the newest treatments for a medical condition.
- Explain benefits and help facilitate access to appropriate care.
- To access Health Advocate 24 hours a day call 866-695-8622 or visit www.healthadvocate.com/une.

Employee Assistance Program

This service is completely confidential and is available to all employees and their household members. Enrollment is automatic for all employees and UNE pays the full cost for this coverage. Benefits include confidential access to the following:

- **Face-to-face counseling sessions:** Up to 6 face-to-face counseling sessions with a counselor in your area.
- **Legal assistance:** 30-minute consultation with an attorney face-to-face or by phone.
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs, and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians, and pet stores.

To access these services, you can call 877-851-1631 or log in to healthadvocate.com/standard6.

403(b) Retirement

UNE's 403(b) Retirement Savings Plan is designed to help you prepare for a secure financial future.

Planning for your future financial security is important. UNE provides 403(b) pre-tax and post-tax retirement savings plan opportunities for full-time and half-time benefit-eligible employees upon your enrollment.

Employees can elect to contribute to any combination of the pre-tax and post-tax savings options up to the IRS annual contribution limits. There is no waiting period to begin contributing. Eligible employees can enroll and increase or decrease their contribution percentage in UNE's 403(b) at any time.

To enroll go to www.netbenefits.com/une and click on the "Register as a New User" link at the bottom of the page. The system will guide you through the enrollment process. If you need help enrolling, please contact the Fidelity Retirement Benefits Line at 1-800-343-0860.

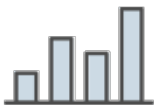
Pre-tax Contributions: UNE will match a participant's pre-tax contributions on a dollar-for-dollar basis, up to a combined match limit with the post-tax Roth contribution of 8%. To be eligible for UNE's match, an employee must have 12 months of service in Higher Education prior to joining UNE or must work for UNE for 12 months.

Post-tax Contributions (Roth): UNE will match a participant's post-tax (Roth) contributions on a dollar-for-dollar basis, up to a combined match limit with the pre-tax contribution of 8%. Roth contributions can be a powerful way to save for retirement, as the employee deferral is typically non-taxable at the time of qualified withdrawal. To be eligible for UNE's match, an employee must have 12 months of service in Higher Education prior to joining UNE or must work for UNE for 12 months.

View these additional resources to determine if Roth contributions may be right for you.


Watch our Roth Video


Roth FAQ's


Roth Modeler


Change contributions

**A distribution from a Roth 403 (b) account is tax free and penalty free, provided the five-year aging requirement has been satisfied and one of the following conditions is met: age 59½, disability, or death.*

Selecting Investments: Participants select their 403(b) retirement plan investment funds directly through Fidelity Investments. Fidelity Investments' representatives and their online retirement planning tools can assist with your retirement planning decisions.

Resources: Through Fidelity, UNE offers a wide range of options to help you learn more about managing your 403(b) retirement. There are online videos, webinars, articles and other tools and resources to help you become more confident in the financial decisions you make today and in the future. Once you establish an account, log in at www.netbenefits.com/une and select "Tools and Resources" then "Education" to access these self-paced learning options. UNE also invites our dedicated Fidelity representative to join us on campus each month so that they can meet with employees one on one to discuss their retirement needs and questions.

Start contributing today! Contributing earlier in your career, even if just a small amount, can make a big difference when you are ready to retire! Remember though, it is never too late to plan for your financial retirement!

Higher Education Benefits

UNE offers employees opportunities for educational enrichment and career development. In addition to your own personal development, your dependents can apply to participate in several higher education tuition benefits offered by the University.

Tuition Grant in Aid

Employees

Benefits-eligible employees are eligible for a 100% UNE tuition waiver for coursework on a space-available basis. Full-time employees are limited to 2 courses per semester; half time employees may take 1 course per semester.

Employee's Dependents

Children

Regular full-time employee's dependents may take course work at a discount for undergraduate course work in non-enrollment capped programs for their dependent child(ren) or stepchild(ren) (to age 24). After merit aid is awarded (if applicable), the remaining balance of tuition will be discounted by 50% for dependents of full-time employees with less than 1 year of full-time service. Once a full-time employee reaches 1 year of full-time service, their dependent will receive a 100% tuition waiver, effective the semester following the employee's attainment of 1 year of full-time service. The chart below illustrates the tuition discount based on continuous years of service:

Tuition Grant in Aid	Discount Percentage
<1 Year	50%
>1 Year	100%

Spouses and Domestic Partners

Spouses and domestic partners of regular full-time employees may take one course per semester (not to exceed four credits per semester), tuition free.

Council of Independent Colleges

Dependent children of full-time UNE employees who have completed at least one year of uninterrupted full-time service are eligible to apply to attend any of the 300+ private independent colleges (participating in the Council of Independent Colleges Program) tuition free. Employees must continue to be employed full-time by UNE for the full duration of the CIC period in order for the benefits to continue. Visit the CIC Web Page (www.cic.edu) for a list of participating CIC-TEP institutions.

Tuition Exchange Program

This program is available to regular full-time UNE employees who have completed at least five years of uninterrupted full-time service (or its equivalent) with the University by their date of application. Employees must continue to be employed full-time by UNE for the full duration of the tuition exchange period in order for the benefits to continue. Visit the Tuition Exchange Program Web Page (www.tuitionexchange.org) for a list of participating colleges.

Please refer to the Personnel Handbook for more detailed information.

Paid Time Off

Holiday Pay

The University provides its employees at least twelve paid holidays per year. When a holiday falls on a Saturday or Sunday, it is generally observed on the preceding Friday or the following Monday. All benefits-eligible employees (except 9 and 10 month faculty) are eligible for paid University holidays. In recognition that people celebrate different holidays, benefits-eligible employees will earn a maximum of two floating holidays per year (earning dates October 1 and March 1).

The usual and customary University holidays are as follows (recognized on Mondays through Fridays):

New Year's Eve	Indigenous Peoples' Day
New Year's Day	Thanksgiving Day
Martin Lurther King Jr. Day	Day after Thanksgiving
Memorial Day	Christmas Eve
Juneteenth	Christmas Day
Independence Day	(2) Floating Holidays
Labor Day	

Personal Time Off

Personal Leave

All full-time benefits-eligible employees earn 8 hours of personal leave upon attaining one year of continuous service, and 8 hours per year thereafter on their employment anniversary date of hire. Half-time benefits-eligible employees earn 4 hours per year in the same manner. Personal leave must be used within the anniversary year following posting.

Sick Leave

All full-time benefits-eligible employees earn 8 hours of sick leave for each completed calendar month of service. Half-time benefits-eligible employees earn 4 hours for each completed calendar month of service. The maximum sick leave accumulation is 1,040 hours for full-time employees and 520 hours for half-time employees.

Vacation Leave

The number of vacation days you earn depends on your position:

- Regular, full-time salaried non-faculty personnel and regular full-time 12-month faculty members earn 20 days (160 hours) of vacation leave per year.
- Regular, full-time hourly personnel working 12 months per year earn:
  - 10 days (80 hours) for each of the first three years of continuous service
  - 15 days (120 hours) for the fourth and fifth years of continuous service
  - 20 days (160 hours) per year after the completion of the fifth year of continuous service.
- Regular, full-time hourly or salaried non-faculty personnel working 9, 10 or 11 months per year earn 9/12ths, 10/12ths or 11/12ths, respectively, of the leave time earned by 12-month employees.
- Regular, half-time non-faculty employees working at least nine months per year earn half the vacation time earned by full-time employees working the same number of months.
- First year vacation is pro-rated on your date of hire.

Employees who earn vacation time may carry forward up to 40 earned and unused vacation hours into the new academic year. Vacation time offered to eligible employees meets the leave time requirements afforded under the Maine Earned Paid Leave Law.

Summer Voluntary Unpaid Personal Time Off

Beginning after Graduation in May through the end of August, regular full-time and half-time salaried and hourly employees may request personal time off without pay, not to exceed three months. Hourly employees can request time off in hourly increments only, and salaried employees can request time off in full day increments only. Department approval is required to ensure that productivity continues without interruption.

Maine Earned Paid Leave Law (MEPL)

Nine (9) or ten (10) month regular faculty members, temporary hourly professional staff, or adjunct faculty members are eligible to earn this leave time benefit. Student workers are not eligible. Hourly employees eligible for MEPL earn 1 hour of MEPL for every forty (40) hours reported on timesheets. Salaried employees eligible for MEPL earn 1 hour for each week worked.

Eligible employees can earn up to a maximum of 40 hours. This leave time can be used for any purpose such as emergency, illness, sudden necessity or planned time off. Employees must be employed with UNE for at least 90 days before they can use their earned MEPL time.

Additional Benefits

Colonial Life Voluntary Benefits

Colonial Life benefits are available through payroll deduction. These policies can be selected to fit your specific needs and budget.

The Colonial Life voluntary benefits provides choices to suit your specific needs for you and your family members. You may select from:

- **Life Insurance:** Term, Whole, Universal (optional LTC Rider)
- **Accident Insurance** that pays specific benefit amounts for injuries received in a covered accident, for as little as $8.96 per pay period for employee coverage, or $16.31 for family. (Optional Disability Income Replacement Rider for your spouse.)
- **Cancer Insurance** that pays specific benefit amounts for the detection and treatment of cancer, for as little as $5.75 per pay period for employee coverage, or $9.75 for family.
- **Critical Illness Insurance** that pays a lump sum benefit upon diagnosis of a covered specified illness such as heart attack, stroke, end stage renal kidney failure, and more. Premium for a sample $5,000 policy is $1.70 per pay period for someone age 24, $2.20 for age 34, $3.38 for age 44, $5.50 for age 54, $8.40 for age 64. Higher coverage amounts are available. Premium does not increase with age after enrollment.

Benefits are paid directly to you, regardless of any other insurance you have. Policies are fully portable when you change jobs or retire.

To learn more or enroll in the Colonial Benefits, please contact Debbie Sullivan at 207-415-1012 or by email at debbie@betterbenefitsme.com. She is our Colonial Benefits Representative and is available for one-on-one virtual meetings.

Additional Discount Programs

Area businesses welcome the patronage of UNE faculty and professional staff. Please note that while we are happy to pass along the information provided to us by these businesses, incentive programs may change without our knowledge. UNE does not recommend or endorse the services or products of any business, but encourages all faculty and professional staff to be educated consumers.

To view a list of discounts available to you, such as cell phone services, ski lift tickets, hotel reservations, local restaurants, and more, along with information about how to access or find out more about these offerings, visit https://une1.sharepoint.com/sites/HR.

Additional Voluntary Benefits

Norton LifeLock Identify Theft Insurance

Employees may purchase voluntary comprehensive identity theft protection through Norton LifeLock. Norton LifeLock offers flexibility allowing you to choose the plan that is best for you and your family.

Features include:

- Monitors for fraudulent use of your social security number, name, address and date of birth in applications for credit and services. Alerts you to potential threats.
- Norton Device Security is included in the membership and allows you to install an antivirus and malware application on your own personal device. This multi layered, advanced security helps protect non-University devices against existing and emerging malware threats, and helps to protect private and financial information when employees go online.
- Provides Norton Family Control, which gives parents the ability to monitor your child's online activity and identify potential dangers before they become an issue.
- Privacy Monitor provides employees with an opportunity to reduce public exposure of their personal information.

The cost is based on the benefit you select (Essential or Premier). There is an easy enrollment process directly with Norton LifeLock, and premiums can be deducted from your UNE paycheck. To learn more, please visit https://www.lifelockbusinesssolutions.com/EmployeeBenefits/Benefitplans.

Nationwide Pet Insurance

Employees may purchase voluntary pet insurance through Nationwide. My Pet Protection from Nationwide offers flexibility allowing you to choose the plan that is best for you and your family.

Features include:

- Ability to see the vet of your choice- there isn't a network.
- You pay the fee at point of service and remit invoices for reimbursement.
- Employees may choose 50% or 70% reimbursement options.
- $250 annual deductible (annual maximum of $7,500)
- Effective 09/01/2023: New members now have the option to select My Pet Protection Wellness500. Existing members can add My Pet Protection Wellness500 during their respective renewal period only, for policies renewing after 10/01/2023.

The cost is based on the pet species and your home zip code (not the age or breed). There is an easy enrollment process directly with Nationwide Pet Insurance, and premiums can be deducted from your UNE paycheck.

NOTE: Pre-existing conditions are not covered. Pre-existing conditions are an illness or injury that your pet had before coverage started. Not all pre-existing conditions are excluded permanently. If you have medical records from your vet showing that your pet's condition has been cured for at least six months, you may be able to get it covered.

To learn more, please visit https://benefits.petinsurance.com/uneedu.

Legal Notices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Employer is committed to protecting the privacy of personal and health information (as defined below) maintained by the Group Health Plans it sponsors for the benefit of its employees and the employees of its affiliates and subsidiaries (collectively referred to as the "Plan").
This Notice of Privacy Practices describes how personal and health information may be used and disclosed. It also describes your rights to access and control your information.
The Plan is required by law to protect the privacy of personal and health information and to provide you with a copy of this notice which describes the Plan's privacy practices. If you have any questions about this notice or would like further information, please contact your Employer's Privacy Officer.
The Plan may make a change to this notice at any time, as long as the change is consistent with applicable state and federal law. If the Plan makes an important change to this notice, the Plan will notify you by mail or electronically as permitted by applicable law. The Plan may also post the revised notice on its web site.

This notice is effective December 1, 2020 and supersedes the notice dated September 16, 2013.
WHAT IS PERSONAL AND HEALTH INFORMATION?

Personal and Health Information (referred to as 'information' elsewhere in this notice) includes protected health information (PHI) and individually identifiable information like your name and social security number. PHI is health information related to your physical or behavioral health condition used in providing health care to you or for payment for health care services. The Plan protects all forms of information including electronic, written and verbal information.

TO WHOM WILL THE PLAN DISCLOSE MY INFORMATION?

The Plan may disclose information to:

The Plan's Business Associates and Business Partners:

- The Plan may contract with other organizations to provide services on the Plan's behalf (e.g., a third party administrator of your health benefits). In these cases, the Plan will enter into an agreement with the organization explicitly outlining the requirements associated with the protection, use and disclosure of your information. These agreements are referred to in this notice as "Business Associate Agreements".

Your Family and Others:

- When you are unavailable to communicate, such as during an emergency
- When you have previously indicated an individual is your personal representative

- When the information is clearly relevant to their authorized involvement with your health care or payment for health care. For example, the Plan may confirm a claim has been received or paid if an individual has prior knowledge of the claim.
- When sharing information about Plan benefits available or your Plan identification number with a spouse or close personal friend who wishes to provide this information to a medical health care professional administering your case.
- When sharing a minor's information with parents who have custodial rights when the information is not further restricted by pertinent state or federal law. Information related to any care a minor may seek and receive without parental consent remains confidential unless the minor authorizes disclosure.

Your Providers and Others Involved in Your Care:

- The Plan may share information with those involved in your care for quality initiatives, safety concerns and coordination of care. Examples include state-mandated quality improvement initiatives, results of laboratory tests not otherwise restricted by law, and clinical reminders sent to your primary care provider.
- Your Plan's third party claims administrator
- When providing certain portions of your information to your Employer as the sponsor of the Plan, for purposes related solely to the Plan's administration. The Employer shall not use any Plan-related information for any purposes unrelated to Plan administration, including without limitation for employment-related actions or decisions. The Employer may only disclose your information to third parties, such as to consultants or advisors, if the Employer has first obtained a Business Associate Agreement from the person or organization receiving your information.

HOW WILL THE PLAN USE AND DISCLOSE MY INFORMATION?

In order to provide coverage for treatment and to pay for those services, the Plan needs to use and disclose your information in several different ways. The following are examples of the types of uses and information disclosures the Plan is permitted to make without your authorization:

FOR PAYMENT

The Plan will use and disclose your information to administer your Plan benefits. This may involve the determination of eligibility, claims payment, utilization review activities, medical necessity review, coordination of benefits, appeals and external review requests.

Examples include:

- Paying claims under the Plan for services received by participants
- Sending information to an external medical review company to determine the medical necessity or experimental status of a treatment
- Sharing information with other insurers to determine coordination of benefits or settle subrogation claims
- Providing information to the Plan's utilization review company for precertification and utilization management services
- Providing information in the billing, collection and payment of premiums and fees to Plan vendors

FOR HEALTH CARE OPERATIONS

The Plan may use and disclose your information for operational purposes, such as care management, coordination of care, quality assessment and improvement, cost analyses, and underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Examples include:

- Assessing the quality of care and outcomes for Plan participants
- Conducting quality assessment studies to evaluate the Plan's performance or the performance of a particular network or vendor
- The use of information in determining the cost impact of benefit design changes
- The disclosure of information to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the Plan (The Plan will not use or disclose any genetic information it might otherwise receive for underwriting purposes.)
- The disclosure of information to stop-loss or reinsurance carriers to obtain claim reimbursements to the Plan
- Disclosure of information to Plan consultants or brokers who provide legal, actuarial and auditing services to the Plan
- Use of information in general data analysis used in the long term management and planning for the Plan
- Engaging in wellness programs, preventive health, early detection, disease management, health risk assessment participation initiatives, case management and coordination of care programs, including sending preventive health service reminders
- Facilitating transition of care from and to other insurers, health plans or third party administrators
- Other general administrative activities, including data and information systems management, risk management, auditing and detection of unlawful conduct

FOR TREATMENT

Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. It also includes but is not limited to consultations and referrals between one or more of your providers. The Plan may disclose your information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) in connection with your treatment. The Plan does not provide treatment. On occasion, the Plan may be required to provide information about you to your providers in order to facilitate treatment.

For example, prior to providing a health service to you, your doctor may ask the Plan for information concerning whether and when the service was previously provided to you.

FOR OTHER PERMITTED PURPOSES

The Plan may use or disclose your information for the following permitted purposes:

- For research subject to certain conditions
- To comply with laws and regulations related to Workers' Compensation.
- For public health activities such as assisting public health authorities with disease prevention or control and with injury or disability control. This can include data collection by state government-mandated or -sponsored consortiums or public health authorities. The Plan may also disclose your information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits the Plan to do so.

- For health oversight activities data may be submitted to a government agency authorized to oversee the health care system or government programs, or to its contractors. Examples include the U.S. Department of Health and Human Services (HHS), a state insurance department or the U.S. Department of Labor for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.
- In response to a court order or an administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.
- To funeral directors or coroners so they can carry out their lawful duties. The Plan may also disclose information about a decedent to the executor, administrator or other person with authority to act on behalf of the decedent's estate.

OTHER REQUIRED USES AND DISCLOSURES

The Plan may use and disclose information about you as required by law. Examples of such situations include:

- To report information related to victims of abuse, neglect or domestic violence
- To prevent serious threat to your health or safety or that of another person
- To authorized federal officials for national security purposes. In addition, under certain conditions, the Plan may disclose your information if you are or were a member of the Armed Forces, for those activities deemed necessary by appropriate military authorities.
- For inmates, to a correctional institution or a law enforcement official having lawful custody, if the provision of such information is necessary to provide you with health care, protect your health and safety, and that of others, or maintain the safety and security of the correctional institution.

WILL THE PLAN USE OR DISCLOSE MY INFORMATION IN WAYS NOT DESCRIBED IN THIS NOTICE?

Other than the uses previously listed, your information will only be used or disclosed with your written authorization. You may revoke such an authorization at any time in writing, except to the extent the Plan has already taken an action based on a previously executed authorization.

To authorize the Plan to use or disclose any of your information to a person or organization for reasons other than those described in this notice, please contact your Employer's Privacy Officer to obtain and complete an authorization form.

The Plan will not use or disclose your information for marketing without your written authorization. Marketing means a communication to encourage you to purchase or use a product or service. Marketing does not include communications about refill reminders or drugs you currently use, case management or care coordination, descriptions about your plan of benefits and related information, and information about treatment alternatives. The Plan will not sell your information without your written authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

WHAT RIGHTS DO I HAVE REGARDING MY INFORMATION?

- Access and Control of Your Information. - The Plan must provide you certain rights with respect to access and control of your information. You have the following rights to access and control your PHI:

- Access and receive copies of your information - You have the right to receive a copy of your information, once you provide the Plan with specific information to fulfill your request. You may ask for an electronic copy of your information and the Plan will provide it if the information is maintained electronically. Information will be provided in the form and format you request, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by you and the Plan. The Plan reserves the right to charge a reasonable fee for the cost of producing and mailing copies of such information.

- Amend your information - If you believe your information is incorrect or incomplete, you have the right to ask the Plan to amend it. In certain cases, the Plan may deny your request and provide you with a written explanation. For example, the Plan may deny a request if the Plan did not create the information, as is often the case for medical information that was generated by a provider, or if the Plan believes the current information is correct.

- Confidential communications - The Plan recognizes you have the right to receive communications regarding your information in a manner and at a location that you feel is safe from unauthorized use or disclosure. To support this commitment, the Plan will permit you to request your information by alternative means or at alternative locations. The Plan will attempt to accommodate reasonable requests.

- Accounting of disclosures - You have the right to request an accounting of those instances in which the Plan or our Business Associates have disclosed your information, during the 6 years prior to the date of your request, for purposes other than treatment, payment or health care operations, or other permitted or required purposes. The Plan will require specific information needed to fulfill your request. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

- Restrictions - You have the right to ask the Plan to place restrictions on the way it is permitted to use or disclose your information. The Plan is not, however, required by law to agree to these requested restrictions. If the Plan does agree to a restriction, the Plan will abide by the restriction unless it is related to an emergency.

Personal Representatives - You have the right to name a personal representative who may act on your behalf to control the privacy of your information. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual;
- or an individual who is the parent of a minor child.

In addition, you will be required to complete a form to name a personal representative. Please contact your Employer's Privacy Officer for assistance.

Notice of Privacy Practice - You have the right to receive a paper copy of this Notice of Privacy Practices upon request at any time, even if you have already received it electronically or have previously agreed to receive it electronically.

Rights under state law - You may be entitled to additional rights under state law to the extent state law applies to the Plan. The privacy laws of a particular state might impose a privacy standard under which the Plan will be required to operate.

Right to be notified of a breach - You have the right to be notified of a breach of your unsecured information.

How do I exercise my rights?
You can exercise all of your privacy rights by contacting your Employer's Privacy Officer. To the extent that the Plan has provided all of your information to a Business Associate (e.g., a third party administrator of your health benefits) you must request access directly from such Business Associate. Please contact your Employer's Privacy Officer for assistance with a request from a Business Associate.

What do I do if I feel my rights have been violated?
If you believe your privacy rights have been violated, you may file a written complaint with your Employer's Privacy Officer.

You may also notify the Secretary of the Department of Health and Human Services (HHS). Send your complaint to:

Medical Privacy, Complaint Division Office for Civil Rights (OCR)
U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201.

You may also call OCR's Voice Hotline at
(800) 368-1019 or you can find more information at www.hhs.gov/ocr.
The Plan will not take retaliatory action against you for filing a complaint.

PRIVACY NOTICES

Health Insurance Portability and Accountability Act (HIPAA) Privacy

UNE will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of UNE.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Newborns' and Mother's Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health and Addiction Equity Act

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that treatment limits applied to mental health and substance use disorder benefits must be at least as generous as the treatment limits applied to medical and surgical benefits. In other words, treatment limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits;
- Treatment limits– such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization to get treatment). The medical benefits offered by the University of New England are compliant with state and federal mental health parity.

Women's Preventive Health

There are several benefits that are in place as a result of the Affordable Care Act (health care reform). These benefits are covered at 100% and may include:
• Contraceptive (birth control) counseling and FDA- approved birth control methods that need a prescription.
• Breastfeeding support, supplies and counseling for females
• HPV (female) testing
• Screenings during pregnancy
Details can be found in the Schedule of Benefits for each plan or by calling Cigna's member services.

Women's Health and Cancer Rights Act (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

This law applies to two different types of coverage:

1. Group health plans (provided by an employer or union);
2. Individual health insurance policies (not based on employment).

Group health plans can either be "insured" plans that purchase health insurance from a health insurance issuer, or "self-funded" plans that pay for coverage directly. How they are regulated depends on whether they are sponsored by private employers, or state or local ("non-federal") governmental employers. Private group health plans are regulated by the Department of Labor. State and local governmental plans, for purposes of WHCRA, are regulated by CMS. If any group health plan buys insurance, the insurance itself is regulated by the State's insurance department.

Contact your employer's plan administrator to find out if your group coverage is insured or self-funded, to determine what entity or entities regulate your benefits. Health insurance sold to individuals (not through employment) is primarily regulated by State insurance departments.

WHCRA requires group health plans and health insurance companies (including HMOs), to notify individuals regarding coverage required under the law. Notice about the availability of these mastectomy-related benefits must be given:

1. To participants and beneficiaries of a group health plan at the time of enrollment, and to policyholders at the time an individual health insurance policy is issued; and
2. Annually to group health plan participants and beneficiaries, and to policyholders of individual policies.

Contact your State's insurance department to find out whether additional state law protections apply to your coverage if you are in an insured group health plan or have individual (non-employment based) health insurance coverage.

WHCRA does not apply to high risk pools since the pool is a means by which individuals obtain health coverage other than through health insurance policies or group health plans.

WHCRA does NOT require group health plans or health insurance issuers to cover mastectomies in general. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Note: A non-Federal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan (opt out) from the requirements of WHCRA by following the "Procedures & Requirements for HIPAA Exemption Election" posted on the Self-Funded Non-Federal Governmental Plans webpage at http://cms.gov/cciio/resources/files/hipaa_exemption_election_instructions_04072011.html. This includes a requirement to issue a notice of opt-out to enrollees at the time of enrollment and on an annual basis. For a list of plans that have opted out of WHCRA, go to http://cms.gov/cciio/resources/other/index.html#nonfed and click on "List of HIPAA Opt-out Elections for Self-funded Non-Federal Governmental Plans."

If you have concerns about your plan's compliance with WHCRA, contact our help line at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov.

General Notice of Cobra Continuation Rights

Employees of The University of New England who are enrolled in the medical/vision, dental, and/or medical FSA plans, have rights to continue this coverage if you were to lose coverage because of a reduction in hours or termination of employment (for reasons other than gross misconduct on your part). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Read this notice carefully to help understand your COBRA rights. Keep in mind that when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Dependent Children
Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

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;
- or 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. You must provide this notice to: The University of New England. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second Qualifying Event Extension
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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

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 ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION: Cat Martins, Human Resources

Important Notice from The University of New England About Your Prescription Drug Coverage and Medicare

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

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

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

2. The University of New England has determined that the prescription drug coverage offered by the Cigna 3500 Basic, Cigna 3000 Enhanced and Cigna HSA Health Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current University of New England coverage will not be affected, unless you decide to drop your medical, which includes prescription drug coverage, under the University of New England Plan. If you keep your medical coverage offered under the University of New England Plan, you will continue to receive all the medical and prescription drug benefits available under the plan. If you drop the prescription drug coverage provided through the University of New England plan, coverage of your other medical benefits under the plan will also be terminated since these benefits are provided on a combined basis.

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 University of New England coverage, be aware that you and your dependents may be able to get this coverage back.

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the University of New England changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

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

Date:	January 1, 2024
Name of Entity/Sender:	The University of New England
Contact--Position/Office:	Cat Martins, Benefits & Leave Manager
Address:	11 Hills Beach Road, Biddeford ME 04005
Phone Number:	207-602-2394
E-Mail:	cmartins@une.edu

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Cat Martins, Benefits & Leave Manager (HR), at 207-602-2394 or cmartins@une.edu

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

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 University of New England		4. Employer Identification Number (EIN) 01-0211810
5. Employer address 11 Hills Beach Road		6. **Employer phone number** 207-602-2394
7. **City** Biddeford	8. **State** ME	9. ZIP **code** 04005
10. Who can we contact about employee health coverage at this job? Cat Martins, Benefits & Leave Manager (HR)		
11. Phone number (if different from above)	12. Email address cmartins@une.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:
- Employees in a full or half-time, regularly budgeted role
- Other employees who meet ACA qualifications (reasonably expected to work 30+ hours/week for greater than 120 days)

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:
- Spouse
- Domestic Partner
- Adopted child, dependent child, stepchild, grandchild, legal guardianship (through age 26)
- Handicapped dependent

☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

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

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

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

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

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

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

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Important Contacts

Please contact the individual company/provider listed here to learn more about a specific benefit plan. We also invite you to contact your Human Resources Department at 207-602-2394.

When You Have Questions About	Contact	Phone Number	Website/Email
Benefits & Enrollment Questions	UNE Human Resources Department	207-602-2283	hr@une.edu
Health	Cigna	866-494-2111	www.my.cigna.com
Health Savings Account (HSA)	HSA Bank	800-357-6246	www.hsabank.com
Vision	Cigna Customer Service	866-494-2111	www.my.cigna.com
Dental	Delta Dental Customer Service	800-832-5700	www.nedelta.com
Flexible Spending Account (FSA)	Flores247	800-532-3327	www.flores247.com
403(b) Retirement Plan	Fidelity	800-343-0860	https://nb.fidelity.com/public/nb/une/home
COBRA	Flores247	800-532-3327	www.flores247.com
Employee Assistance Program (EAP)	EAP Member Services	877-851-1631	//healthadvocate.com/standard6 answers@healthadvocate.com
Health Advocate	Health Advocate	866-695-8622	healthadvocate.com/members email: answers@healthadvocate.com
Life/AD&D	The Standard	800-628-8600	www.standard.com email: lifebenefits@standard.com
Long Term Disability	The Standard	800-368-1135	www.standard.com
Short Term Disability	The Standard	800-368-2859	www.standard.com
Voluntary Benefits	Colonial Life	207-828-8016	www.coloniallife.com

Summary Plan Descriptions can be found at https://www.une.edu/hr/benefits. The various insurance plans are listed, and the SPD's can be found within each link. If you wish to have a printed copy please contact Human Resources and we would be happy to provide this at no cost.

Consult the various plan documents and/or Personnel Handbook to determine full eligibility and details of the various benefits noted throughout this Benefits Guide.

VARNEY
BENEFITS ADVISORS

UNE
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INNOVATION FOR A HEALTHIER PLANET

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