PURDUE GLOBAL UNIVERSITY

2026

Compliance Guide

Contact Name	Human Resources
Phone	765-494-2222
Mailing Address	Purdue University Global 2550 Northwestern Ave. Ste. 1100 West Lafayette, IN 47906

You may request paper copies of all notices, free of charge, upon request to the Plan Administrator.

Presented by:

LHD Benefit Advisors

PURDUE GLOBAL UNIVERSITY

Legal Notices for 2026

The Employee Retirement Income Security Act (ERISA), Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service require plan administrators to provide certain information related to their health and welfare benefits plan to plan participants in writing. To satisfy this requirement, please review the compliance notifications included in this package. These notices explain your rights and obligations in relation to the health and welfare plan provided by **Purdue University Global**.

Please read these notices carefully and retain a copy for your records:

- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
- WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE
- NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE
- PATIENT PROTECTION NOTICE
- NOTICE OF PRIVACY PRACTICES:
- HIPAA SPECIAL ENROLLMENT NOTICE
- PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
- GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURES
- YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
- EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)
- MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)
- USERRA NOTICE
- MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
- FAMILY MEDICAL LIEAVE ACT (FMLA)
- MEDICARE PART D CREDITABLE
- MARKET EXCHANGE
- NOTICE REGARDING WELLNESS PROGRAM

Legal Notices for 2026

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses.
3. Treatment of physical complications of the mastectomy, including lymphedema.

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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). Please refer to your plan document for more information about childbirth coverage.

PATIENT PROTECTION NOTICE

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, a list of the participating primary care providers, or a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator using the number on the back of your ID card.

Legal Notices for 2026

NOTICE OF PRIVACY PRACTICES:

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your health information that the plan creates, requests, or is created on the Plan's behalf, called Protected Health Information ("PHI") and to provide you, as the participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information.

The terms of this Notice of Privacy Practices ("Notice") apply to the following plans (collective and individually referenced in this Notice as the "Plan"): Group Medical and Prescription Drug Plans, Voluntary Dental Plans, and Voluntary Vision Plan

This Notice describes how the Plan may use and disclose your PHI to carry-out payment and health care operations, and for other purposes that are permitted or required by law.

The Plan is required to abide by the terms of this Notice so long as the Plan remains in effect. The Plan Reserves the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by the Plan. Copies of revised Notices in which there has been a material change will be mailed to all participants then covered by the Plan. Copies of our current Notices may be obtained by calling the plan administrator.

DEFINITIONS

Plan Sponsor means Employer Entity defined on page one and any other employer that maintains the Plan for the benefit of its associates.

Protected health Information ("PHI") means individually identifiable health information, which is defined under the law as information that is a subset of health information, including demographic information, that is created or received by the Plan and that relates to your past, present or future physical mental health or condition; the health care services you receive, or the past, present, or future payment for health care services you receive; and that identifies you, or which there is a reasonable basis to believe the information can be used to identify you.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that the Plan may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and, when appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below or otherwise permitted by law, the Plan will not use or disclose your PHI unless you have signed a form authorizing the Plan to use or disclose specific PHI for an explicit purpose to a specific person or group of persons. Uses and disclosures of your PHI for marketing purposes and/or for the sale of your PHI require your authorization. You have the right to revoke any authorization in writing except to the extent that the Plan has taken action in reliance upon the authorizations.

Uses and Disclosures for Payment – The Plan may use and disclose your PHI as necessary for benefit payment purposes without obtaining an authorization from you. The persons to whom the Plan may disclose your PHI for payment purposes include your health care providers that are billing for or requesting a prior authorization for their services and treatments of you, other health plans providing benefits to you, and your approved family member or guardian responsible for amounts, such as deductibles and co-insurance, not covered by the Plan.

For example, the Plan may use or disclose your PHI, including information about any medical procedures and treatments you have received, are receiving, or will receive, to your doctor, your spouse's doctor or other health plan under which you are covered, and your spouse or other family members, unless you object, in order to process your benefits under the Plan. Examples of other payment activities include determinations of your eligibility or coverage under the Plan, annual premium calculations based on health status and demographic characteristics of persons covered under the Plan, billing, claims management, reinsurance claim, and review of health care services with respect to medical necessity, utilization review activities, and disclosures to consumer reporting agencies.

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Uses and Disclosures for Health Care Operations – The Plan may use and disclose your PHI as necessary for health care operations without obtaining an authorization from you. Health care operations are those functions of the Plan it needs to operate on a day-to-day basis and those activities that help it to evaluate its performance. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, amendment or termination of the Plan, and obtaining reinsurance coverage. Other functions considered to be health care operations include business planning and development; conducting or arranging for quality assessment and improvement activities, medical review, and legal services and auditing functions; and performing business management and general administrative duties of the Plan, including the provision of customer services to you and your covered dependents.

Use or Disclosure of Genetic Information Prohibited – the Genetic Information Nondiscrimination Act of 2009 (GINA), and regulations promulgated thereunder, specific prohibit the use, disclosure or request of PHI that is genetic information for underwriting purposes. Genetic information is defined as (1) your genetic tests; (2) genetic tests of your family member; (3) family medical history, or (4) any request of or receipt by you or your family members' genetic services. This means that your genetic information cannot be used for enrollment, continued eligibility, computation of premiums, or other activities related to underwriting, even if those activities are for purposes of health care operations or being performed pursuant to your written authorization.

Family and Friends Involved in Your Care – If you are available and do not object, the Plan may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and the Plan determines that a limited disclosure is in your best interest, the Plan, may share limited PHI with such individuals. For example, the Plan may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish us to share PHI with your spouse or others, you may exercise your right to request a restriction on your disclosure of your PHI (see below), including having correspondence the Plan sends to you mailed to an alternative address. The Plan is also required to abide by certain state laws that are more stringent than the HIPAA Privacy Standards, for example, some states give a minor child the right to consent to his or her own treatment and, under HIPAA, to direct who may know about the care he or she receives. There may be an instance when your minor child would request for you not to be informed of his or her treatment and the Plan would be required to honor that request.

Business Associates – Certain aspects and components of the Plan's services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our third-party administrator, reinsurance carrier, agents, attorney, accountants, banks and consultants. At times it may be necessary for use to provide certain of your PHI to one or more of these outside persons or organizations. However, if the Plan does provide your PHI to any or all of these outside persons or organizations, they will be required, though contract or by law, to follow the same policies and procedures with your PHI as detailed in this Notice.

Plan Sponsor – The Plan may disclose a subset of your PHI, called summary health information, to Plan Sponsor in certain situations. Summary health information summarizes claims history, claim expenses, and types of claims experience by individuals under the Plan, but all information that could effectively identify whose claims history has been summarized has been removed. Summary health information may be given to the Plan Sponsor when requested for the purpose of obtain premium bids, for providing coverage under the Plan, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor whether you are enrolled in or have disenrolled from the Plan.

Other Products and Services – The Plan may contact you to provide information about other health-related products and services that may be of interest to you without obtaining your authorizations. For example, the Plan may use and disclose your PHI for the purpose of communicating to you about the health benefit products or services that could enhance or substitute for existing coverage under the Plan, such as long-term health benefits for flexible spending accounts. The Plan may also contact you about health-related products and services, like disease management programs that may add value to you, as a covered person under the Plan. However, the Plan must obtain your authorization before the Plan sends you information regarding non-health related products or services, such as information concerning movie passes, life insurance products, or other discounts or services offered to the general public at large.

Other Uses and Disclosures – Unless otherwise prohibited by the law, the Plan may make certain other uses and disclosures of your PHI without your authorization, including the following:

The Plan may use or disclose your PHI to the extent that the use or disclosure is required by law. The Plan may disclose your PHI to the proper authorities if the Plan suspects child abuse or neglect; the Plan may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence. The Plan may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or a civil or criminal proceeding. The Plan may disclose your PHI in response to a court order specifically authorizing the disclosure, or in the course of a judicial or administrative proceeding (e.g. to response to a subpoena or discovery request), provided written and documented efforts by the requesting party have been made to (1) notify you of the disclosure and the purpose of the litigation, or (2) obtain a qualified protective order prohibiting the use or disclosure of your PHI for any other purpose than the litigation or proceeding for which it was requested.

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The Plan may disclose your PHI to the proper authorities for law enforcement purposes, including the disclosure of certain identifying information requested by police officers for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; the disclosure of your PHI if you are suspected to be a victim of a crime and you are incapacitated; or if you are suspected of committing a crime on the Plan (e.g., fraud).

The Plan may use or disclose PHI to avert a serious threat to health or safety.
The Plan may use or disclose your PHI if you are a member of the military, as required by armed forces services, and the Plan may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
The Plan may disclose your PHI to state or federal workers' compensation agencies for your workers' compensation benefit determination.
The Plan may, as required by law, release your PHI to the Secretary of Department Health and Human Services for enforcement of HIPAA Privacy Rules.

Verification Requirement – Before the Plan discloses your PHI to anyone requesting it, the Plan is required to verify the identity of the requester's authority to access your PHI. The Plan may rely on reasonable evidence of authority such as a badge, official credentials, written statements on appropriate government letterhead, written or oral statements of legal authority, warrants, subpoenas, or court orders.

RIGHTS THAT YOU HAVE

To request to inspect, copy, amend or get accounting of PHI pertaining to your PHI in the Plan, you may contact the plan administrator.

Right to Inspect and Copy your PHI – You have the right to request a copy of and/or to inspect your PHI that the Plan maintains, unless the PHI was compiled in reasonable anticipation of litigation or contains psychotherapy notes. In certain limited circumstances, the Plan may deny your request to copy and/or inspect your PHI. In most of those limited circumstances, a licensed health care provider must determine that the release of the PHI to you or a person authorized by you, as your "personal representative," may cause you or someone else identified in the PHI harm. If your request is denied, you may have the right to have the denial reviewed by a designated licensed health care professional that did not participate in the original decision. Request for access to your PHI must be in writing and signed by you or your personal representative. You must ask for a Participant PHI Inspection Form from the Plan through the plan administrator. If you request that the Plan copy or mail your PHI to you, the Plan may charge you a fee for the cost of copying your PHI and the postage for mailing your PHI to you. If you as the Plan to prepare a summary of PHI, and the Plan agrees to provide that explanation, the Plan may also charge you for the cost associated with the preparation of the summary.

Right to Request Amendments to Your PHI – You have the right to request that PHI the Plan maintains about you be amended or corrected. The Plan is not obligated to make requested amendments to PHI that is not created by the Plan, not maintained by the Plan, not available for inspection, or that is accurate and complete. The Plan will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your personal representative, must state the reasons for the amendment request, and must be sent to the Privacy Office at the address below. If the Plan denies your amendment request, the Plan will provide you with its basis for the denial, advise you of your right to prepare a statement of disagreement which it will place with your PHI, and describe how you may file a complaint with the Plan or the Secretary of the US Department of Health and Human Services. The Plan may limit the length of your statement of disagreement and submit its own rebuttal to accompany your statement of disagreement. If the Plan accepts your amendment request, it must make a reasonable effort to provide the amendment to persons you identify as needing the amendment or persons it believes would rely on your unamended PHI to your detriment.

Right to Request an Accounting for Disclosures of Your PHI – You have the right to request an accounting of disclosures of your PHI that the Plan makes. Your request for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Not all disclosures of your PHI must be included in the accounting of the disclosures. Examples of disclosures that the Plan is required to account for include those pursuant to valid legal process, or for law enforcement purposes. Examples of disclosures that are not subject to an accounting include those made to carry out the Plan's payment or health care operations, or those made with your authorization. To be considered, your accounting requests must be in writing and signed by you or your personal representative, and sent to the Privacy Office at the address below. The first accounting in any 12-month period is free; however, the Plan may charge you a fee for each subsequent accounting you request within the same 12-month period.

Right to Place Restrictions on the Use and Disclosure of Your PHI – You have the right to request restrictions on certain of the Plan's uses and disclosures of your PHI for payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that the Plan not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. The Plan is not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. The Plan retains the right to terminate an agreed-to restriction if it believes such termination is appropriate. In the event of a termination by the Plan, it will notify you of the termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting the Plan through the Privacy Office at the telephone number or address below.

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Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger. The Plan may grant other requests for confidential communications in its sole discretion. Requests for confidential communications must be in writing, signed by you or your personal representative, and sent to the Privacy Office at the address below.

Uses and Disclosures Requiring Authorization – Our group health plan is required to comply with federal laws that provide additional privacy protections for records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected under 42 C.F.R. Part 2.
In general, the Plan may not use or disclose substance use disorder records without your written authorization, except as permitted or required by law. When authorization is required, it must specifically permit the use or disclosure of substance use disorder records.
Any authorization you provide may be revoked by you in writing at any time, except to the extent the Plan has already taken action in reliance on the authorization.
Substance use disorder records disclosed with your authorization may not be re-disclosed by the recipient unless permitted by federal law.
To operate the group health plan, certain health information may be disclosed to the Plan Sponsor for plan administration purposes as permitted by HIPAA. Substance use disorder records, however, will not be disclosed to the Plan Sponsor without your authorization unless such disclosure is permitted or required by federal law.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting the Privacy Office at the telephone number or address below.

Right to Notice of Breach - You have the right to receive notice if your PHI is improperly used or disclosed as a result of a breach of unsecured PHI.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with the Plan through the plan administrator in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our plan administrator.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2025**. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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

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

To see if any other states have added a premium assistance program since July 31, 2025, 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)

PURDUE GLOBAL UNIVERSITY

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURES

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Pursuant to the No Surprises Act, group health plans and health insurance issuers offering group or individual health insurance coverage must make publicly available, post on a public website of the plan or issuer, and include on each Explanation of Benefits, information in plain language on the restrictions on balance billing in certain circumstances, any applicable state law protections against balance billing, the requirements of the Act, and information on contacting appropriate state and federal agencies to report suspected violations of these balance billing restrictions. Plans and issuers may use this model notice to meet the disclosure requirements. For more information and further instructions, see https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgery center, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency Services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The MHPAEA imposes parity requirements on group health plans that provide benefits for mental health or substance use disorders. For example, plans must offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits.

The MHPAEA applies to group health plans offering mental health and substance use disorder benefits. There is an exception for health plans that can demonstrate a certain cost increase and an exception for small health plans with fewer than two participants who are current employees (for example, retiree health plans). There is also an exception for employers with 50 or fewer employees during the preceding calendar year. However, in order to satisfy the essential health benefits requirement, mental health and substance use disorder benefits must be provided in a manner that complies with the MHPAEA. Thus, through this ACA mandate, small employers with insured plans are also subject to the mental health parity requirements.

Under the MHPAEA, the plan administrator or the health insurance issuer must disclose the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits to any current or potential participant, beneficiary or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits to the participant or beneficiary.

USERRA NOTICE

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

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

B. Reemployment Rights

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

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

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

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

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

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets*. An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

COBRA

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

COBRA

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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.

COBRA

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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.

How is COBRA continuation coverage provided?
Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Family Medical Leave Act (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

Benefits & Protections

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Family Medical Leave Act (FMLA)

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Medicare Part D Creditable

IMPORTANT NOTICE FROM PURDUE UNIVERSITY GLOBAL 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 **Purdue University Global** 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. Purdue University Global has determined that the prescription drug coverage offered by **UMR** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current **Purdue University Global** creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **Purdue University Global** coverage, be aware that you and your dependents may not 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 **Purdue University Global** 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.

Medicare Part D Creditable

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 **Purdue University Global** health plan provided by **UMR** 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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**October 1, 2025**
Name of Entity/Sender:	**Purdue University Global**
Contact Position/Office:	**Human Resources**
Address:	**2550 Northwestern Ave.** **Suite 1100** **West Lafayette, IN 47906**
Phone Number:	**765-494-2222**

Market Exchange

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

Market Exchange

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact.

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.

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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 Purdue University Global		4. Employer Identification Number (EIN) 82-1319401
5. Employer address 2550 Northwestern Ave. Suite 100		6. Employer phone number 765-494-2222
7.City West Lafayette	8. State IN	9. ZIP code 47906
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address hr@purdue.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 are considered eligible for medical benefits if they are employed half time (0.50 FTE) or more on a continuing basis for more than one year (unless stated otherwise) in the following classes:			
Executive	M/P Management	Service - except Associate Tutors who fall below 30 hours per week	Faculty

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  - Your legal spouse. When a person is no longer your legal spouse, that person no longer qualifies as your eligible dependent.
  - Each dependent child (as defined by the IRS) until the end of the month in which that child reaches his or her 26th birthday. IRS dependency is not required.

  ☐ 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.

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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

Notice Regarding Wellness Program

JANUARY 1 – DECEMBER 31, 2026

Purdue University Global's Wellness Incentive Program is a voluntary wellness program available to all benefits-eligible employees and to their spouses on a Purdue University Global health plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a physical. You are not required to complete the physical; however, employees and their covered spouses who choose to do so will receive an incentive of up to $100 per individual.

Employees and their covered spouses who complete the physical also have the option to complete a biometric screening to earn an additional cash incentive of up to $50 per individual. The biometric screening involves a blood test for A1c, fasting glucose, triglycerides, HDL and LDL cholesterol levels and provides weight, height, and blood pressure.

The data from your physical and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Incentive Program and Purdue University Global may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 855-424-0400.