2027 Benefits Open Enrollment Guide







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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 63 for more details.

Welcome to your 2027 Benefit Guide

Everglades College Inc. dba Keiser University & Everglades University is proud to serve you and your family through our 2027 Health and Welfare Benefits Plan. We understand that our employees have diverse needs, and so we have developed a well-rounded plan capable of helping to protect you and your family members in the event of illness or injury.

This Benefits Information Guide provides necessary plan and program information to help you understand your many benefit options and ultimately enroll in the benefits that work best for you and your family for the 2027 Plan Year.

This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact your Plan Administrator:

Benefits Department - Human Resources
Benefits@keiseruniversity.edu



Benefit Offering Directory

	Carrier Options	Contact
Medical/Rx & GAP	Cigna Medical Plan	1-800.CIGNA24 https://www.mycigna.com
	Cigna Rx	1-800-835-3784 https://www.mycigna.com
	CanaRx	1-866-893-6337 https://www.canarx.com
	Fidelity Security Life Insurance Company Amwins / Medical GAP Plan	1-925-278-5601 www.webtpa.com
Dental	Cigna DPPO Plans Cigna DHMO Plan	1-800.CIGNA24 https://www.mycigna.com
Vision	Cigna Vision	1-888-353-2653 https://www.mycigna.com
Life & Disability	UnitedHealthcare Basic Life & AD&D UnitedHealthcare Voluntary Life & AD&D UnitedHealthcare Long-Term Disability UnitedHealthcare Short-Term Disability	1-866-801-4409 Claims: 1-888-299-2070 www.myuhcfp.com
Additional Benefits	Spending Account Service Center Health Savings Account (HSA)	1-800-580-6854
	Spending Account Service Center Flexible Spending Accounts (FSAs)	1-800-580-6854
	UnitedHealthcare Worksite Products (Accident, Hospital, and Critical Illness)	1-866-801-4409 www.myuhcfp.com
	LegalShield Legal Plan	1-888-807-0407 www.legalshield.com
	Health Advocate	1-866-799-2728 HealthAdvocate.com/members
	Beyond Med	info@beyondmedplans.com www.beyondmedplans.com

What's New for 2027

This section constitutes a Summary of Material Modifications (SMM) to the Summary Plan Description (SPD) for the Plan, thereby modifying the information previously presented in the SPD with respect to the Plan.

You should review this information carefully and share it with your covered dependents. Keep this information with your SPD for future reference. In the event of a conflict between the official Plan Document and this SMM, the SPD, or any other communication related to the Plan, the official Plan document(s) will govern.

The following updates to benefit coverage under the EVERGLADES COLLEGE, INC health and welfare plans will take effect on January 1, 2027.

Medical Plan Changes

This year, our medical benefits will continue with Cigna, and we will now offer three medical options instead of five. The table below shows how this year's plans being offered.

Cigna Plans 2027
1. OAP HDHP HSA $4,000 - 20% (In & Out of Network) 2. OAP $2000 – 10% (In & Out of Network) 3. OAP $0 - 0% (In & Out of Network)

OAP = Open Access Plus (In & Out of Network)

Plan options and rates are detailed in the Medical Benefits section, and you can review the full Summary of Benefits and Coverage (SBC) for a comprehensive overview of this year's offerings.

Hinge Health

New this year, Hinge Health's Full Digital Musculoskeletal Clinic (Full DMC) provides personalized musculoskeletal support through care pathways for acute, chronic, prevention, surgery, and Women's Pelvic Health. Eligible employees, spouses, and dependents age 18 and older will be matched to the program that best fits their needs after completing the enrollment questionnaire.

CanaRx

CanaRx is a new employee benefit that offers convenient home delivery of select eligible brand-name maintenance medications. With zero copays on member copayments covered under the program and no shipping or handling charges, CanaRx makes accessing medications simpler and more affordable.

If you have difficulty understanding any part of this document, contact your Plan Administrator:

Human Resources - Benefits Department
954-776-4476
Benefits@keiseruniversity.edu

Benefit Enrollment Information

When do I Enroll?

Current employees will make all your benefit elections for the upcoming plan year during Open Enrollment from **October 5, 2026 - October 19, 2026**. During this time, you will be able to enroll in new benefits, change your current elections, and add or remove dependents.

These changes or additions will be effective from **January 1, 2027, through December 31, 2027.**

How do I Enroll?

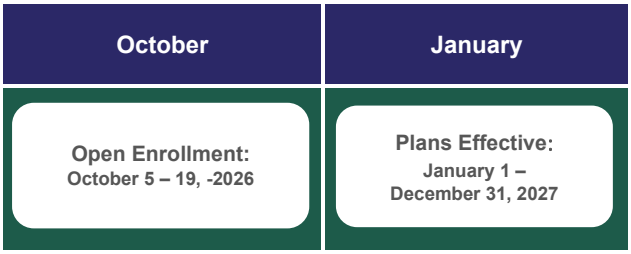
To access the benefits portal, please go to the benefits portal, PlanSource site at https://benefits.plansource.com

- Your user credentials will be sent on October 2, 2026 by email from no-reply@plansource.com. Note there is a dash between "no" and "reply"
- Anyone hired after this date would refer to their new hire credentials email from PlanSource or can contact Benefits for them.
- Your temporary password is your date of birth in "YYYYMMDD" format.

Who Can Enroll?

There are certain restrictions surrounding eligibility for benefit enrollment. If you are classified as a full-time employee scheduled 30 hours or more per week, you will be eligible for benefits on the 1st of the month following 30 days of employment.

If you meet the above requirements, your legal spouse, domestic partner, or dependent child(ren) are also eligible for our benefits plan.



As a reminder, a dependent child is:

- your natural born child,
- legally adopted child,
- stepchild,
- a child you have been appointed legal guardian of as a foster parent,
- a child you are required to cover under a Qualified Medical Child Support Order, or
- a child who is totally and permanently disabled, incapable of self-support because of a mental or physical handicap, and is financially supported by you.

Please note that your dependent children are generally eligible only up until age 26 but can be eligible up until age 30 if they meet specific requirements.

- Dependent is unmarried and does not have a dependent of his or her own; AND
- Dependent is a resident of Florida OR a full-time or part-time student; AND
- Dependent is not provided coverage under any other health insurance policy, including Medicare or Medicaid.

Please Note: Employees providing health coverage to a domestic partner or children over the age of 25 (who are not tax dependents under IRS rules), are required to have imputed income for the health coverage market value of the covered person(s) added to their earnings and will pay taxes on those earnings.

Benefit Enrollment Information

Benefit Termination Rules

Should your employment terminate, or your work status change, making you ineligible for benefits, your benefits will terminate the last day of the month. Employees are responsible for premiums for the month.

Your dependent children are generally eligible only up until age 26 but can be eligible up until the end of the year that they turn age 30 on your medical plan if they meet specific requirements. See notes under “Who Can Enroll” on the previous page.

Making Plan Changes

Existing employees can only make plan changes during the Initial Enrollment window and cannot make additional changes to your coverage during the year unless you experience a qualified family status change. Below, we have included a few examples of qualified family status change events:

1. Special Enrollment Events (Add coverage for yourself and/or dependents).
    - Involuntary loss/gain of other group coverage
    - Acquisition of new dependent through marriage, birth, or adoption
    - Change in Medicaid or CHIP eligibility

2. IRC Section 125 Status Change Events (Add, cancel, or change coverage for yourself and/or dependents).
    - Involuntary loss or gain of other group coverage
    - Divorce
    - Death of covered spouse or child
    - Change in employment status
    - Medicare entitlement

If you think you have experienced a qualified family status change event, you will need to verify the event with Human Resources within 30 days of its occurrence. (60 days in the case of Medicaid or CHIP eligibility)

IMPORTANT

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of the covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Open Enrollment Cheat Sheet

Open enrollment is reserved for employees to make changes to their benefits elections. This yearly period allows you to change or renew your health care coverage for the upcoming calendar year.

Understanding your employee benefits can feel overwhelming, especially if the vocabulary surrounding benefits is unfamiliar to you. Learning the terminology can help you feel more confident when choosing or reviewing your coverage.

Use these definitions of common open enrollment terms to help you navigate your benefits options.

Common Open Enrollment Terms

Annual physical exam is a yearly preventative visit to a primary care provider (General practitioners, Internists and Family Medicine providers) to assess overall health, screen for potential issues, update necessary vaccinations, and discuss lifestyle factors to promote wellness. These checkups can involve measuring vital signs, performing physical examinations of different body parts and ordering tests like blood work or imaging to detect or prevent conditions like high blood pressure, high cholesterol, or chronic diseases before they become serious.

Coinsurance is the amount or percentage you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and it can vary based on the plan design.

Copayment (copay) is a flat fee that you pay toward the cost of covered medical services.

Covered charges are health care expenses that are covered under your health plan.

Deductibles are a specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependents are individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible spending accounts (FSAs) are accounts that allow you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Maintenance Organizations (HMOs) are types of health insurance plans that usually limit coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copayment is due for each office visit and hospital stay. HMOs require you to select a primary care physician responsible for managing and coordinating all of your health care.

Health reimbursement arrangements (HRAs) are employer-owned medical savings accounts in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account to reimburse qualified health care expenses.

Health savings accounts (HSAs) are employee-owned medical savings accounts used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high deductible health plans (HDHPs).

High deductible health plans (HDHPs) are qualified health plans that combine very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-network is health care received from your primary care physician or a specialist within an outlined list of health care practitioners.

Inpatient refers to a person who is treated as a registered patient in a hospital or other health care facility.

Medically necessary (or medical necessity) are services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare is an insurance program administered by the federal government to provide health coverage to individuals aged 65 and older or who have specific disabilities or illnesses.

Members are those enrolled in a health plan. This includes eligible employees, their dependents, Consolidated Omnibus Budget Reconciliation Act (COBRA) beneficiaries and surviving spouses.

Out-of-network is health care you receive without a physician referral or services received from a nonnetwork service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket expenses are the amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket maximums (OOPMs) are the highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organizations (PPOs) are health plans that offer both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium is the amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary care physicians (PCPs) are doctors who are selected to coordinate treatment under your health plan. This generally includes Family Practice Physicians, General Practitioners, Internists and Pediatrician.

This cheat sheet does not account for every term or definition you may see during open enrollment, but it provides an overview of some of the most common ones. If you have questions, check with your employer for further resources.

This infographic is to be used for informational purposes only and is not intended to replace the advice of an insurance professional. © 2025 Zywave, Inc. All rights reserved

Health Plans



This section will review the following health plans:

- **Medical**
- **Dental**
- **Vision**

Medical Plans

Everglades College Inc. dba Keiser University & Everglades University offers three **Cigna** medical plans:

- OAP HDHP HSA $4,000-20% Plan (In and Out of Network)
- OAP $2000 – 10% Plan (In and Out of Network)
- OAP $0-0% Plan (In and Out of Network)

Here is a closer look at how Cigna's medical plan options work. You will find more plan highlights as well as your contributions on the following page.

PPO (OAP Plan): Open Access Plus in-network only, offers flexibility to see any healthcare provider, including specialists, without a referral, in-network.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA): This plan covers services performed by in-network and out-of-network health care providers. In-network services yield the highest level of benefits with the lowest out-of-pocket expenses because services are paid based on contracted rates. Those who participate in this plan may be eligible to open a Health Savings Account (HSA).

NOTE: Bi-weekly payroll deductions do not cover all expenses such as copays and deductibles.

Imputed Income will be added to employee earnings for employees who provide healthcare to domestic partners and children over the age of 25.



Medical Plans

COVERAGE	OAP HDHP HSA $4,000-20% In and Out of Network	OAP $2000 – 10% In and Out of Network	OAP $0-0% In and Out of Network
Calendar Year Deductible (DED)			
Individual	$4,000	$2,000	$0
Family	$8,000	$4,000	$0
Member Coinsurance			
	20%	10%	0%
Calendar Year Out-of-Pocket			
Individual Maximum	$6,500	$5,000	$4,000
Family Maximum	$13,000	$10,000	$12,000
Physician Visit			
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Primary Care Physician (PCP) • *Tier 1 providers* • *Non-Tier 1 providers*	20% after DED	$0 copay / $35 copay	$0 copay / $25 copay
Specialist • *Tier 1 providers* • *Non-Tier 1 providers*	20% after DED	$0 copay / $50 copay	$0 copay / $50 copay
Convenience Clinic	20% after DED	$25 copay	$25 copay
Lab Work and Diagnostic Imaging			
Independent Lab i.e., blood work, X-ray	20% after DED	Covered in Full	Covered in Full
Advanced Services Includes MRI, PET, CT • *Preauthorization may be required* • *Costs for services may differ based on location where the service was rendered*	20% after DED	$300 copay	$300 copay
Hospital Services			
Inpatient Hospital	20% after DED	$500 copay	$300 copay
Outpatient Surgery • *Costs for services may differ based on location where the service was rendered*	20% after DED	$300 copay	$200 copay
Emergency Medical Care			
Urgent Care	20% after DED	$75 copay	$75 copay
Emergency Room	20% after DED	$300 copay (waived if admitted)	$250 copay (waived if admitted)
Prescription Drugs (30-day supply)			
Generic and Specialty generic, tier 1	$10 copay after DED	$15 copay	$10 copay
Brand Preferred, tier 2	$35 copay after DED	$40 copay	$35 copay
Brand Non-Preferred, tier 3	$60 copay after DED	$70 copay	$60 copay
Specialty Brand Preferred, tier 4	$70 copay after DED	$90 copay	$70 copay
Specialty Brand Non-preferred, tier 5	$120 copay after DED	$150 copay	$120 copay
Prescription Drugs Mail Order			
90-day supply – excluding specialty drugs	2x retail	2x retail	2x retail
Out of Network			
OON Member Coinsurance	40%	40%	40%
OON Deductible Ind/Fam	$7,000 / $14,000	$4,000 / $8,000	$3,000/$9,000
OON Out-of-Pocket Maximum Ind/Fam	$10,000 / $20,000	$10,000 / $20,000	$8,000/$24,000

Out-of-network services are always subject to balance billing. Member will be responsible for payment of the difference between Cigna's allowable charges and the provider's actual fee.

If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier policy and summary plan description prevail.

Manage your pharmacy plan on myCigna

myCigna is your "go to" for everything you need to know about your plan coverage.

See which medications your plan covers. You have hundreds of generic, preferred brand and non-preferred brand medications to choose from.

Compare your medication costs. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.[1]

Easily manage all of your prescriptions on the My Medications page.
Click on the Prescriptions tab in the myCigna menu to access My Medications

- View your prescriptions filled within the last 18 months
- Use the myCigna App to review your medications with your doctor during an office visit
- Move your prescription from a retail pharmacy to Express Scripts® Pharmacy, your home delivery pharmacy, with the click of a button[2]
- For retail pharmacy fills: View where and when you last filled your medications
- For home delivery fills: Get real-time order status and tracking, sign up for automatic refills, pay bills online, sign up for a payment plan and more
- For specialty medications: Easily connect to your online Accredo® account to manage orders[2]

Find an in-network retail pharmacy. If you're on the go, use the **myCigna App** to see a list of pharmacies near you.

View your plan information. See your pharmacy claim history, coverage details and account balances.

1. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
2. Not all plans offer Express Scripts® Pharmacy and Accredo as covered pharmacy options. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare maintains an ownership interest in Express Scripts® Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized regardless of where you fill your prescriptions.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

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cigna healthcare

Health care that's there for you when and where you need it.

Head-to-toe virtual care from MDLIVE.



Virtual care is making access to high-quality healthcare more convenient and affordable – for you and every covered member of your family. That's why Cigna Healthcare℠ has partnered with MDLIVE® to offer a broad suite of convenient virtual care options – available by phone or video, and in English or Spanish

Primary Care[1]

Easy, fast appointments, referrals, prescriptions, lab work and diagnostic tests

- Preventive care and wellness screenings available at no additional cost to identify conditions early[2]
- Manage chronic conditions and establish a relationship with the same primary careprovider (PCP) through routine care.
- Receive orders for biometrics and blood work at local facilities[3]

Urgent Care

Available via E-Treatment, phone or video.[5]

- Convenient, affordable alternative to urgent care centers and the emergency room
- Care for many minor illnesses and injuries, such as infections, cold & flu, and sinus problems
- Includes pediatric care, allowing your child to be seen quickly and from the comfort of their home

Dermatology[4]

Fast, customized care for skin, hair, and nail conditions – no appointment required

- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Upload photos and describe symptoms for board-certified dermatologists to review
- Diagnosis and customized treatment plan, usually within 24 hours

Behavioral Care

Talk therapy and psychiatry from the privacy of home, with no waiting rooms

- Access to licensed therapists and board-certified psychiatrists
- Schedule an appointment that works for you andhave recurring sessions with the same provider
- Care for topics such as anxiety, stress, life changes, grief and depression

Prescriptions available through home delivery or at local pharmacies, if appropriate.

Disclosures listed on next page.

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cigna healthcare

It's easy to connect to care.

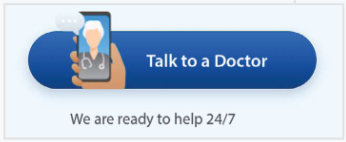
Virtual care visits are convenient and easy, whether you choose on-demand care or to schedule an appointment. And you can select an appointment in English or Spanish.

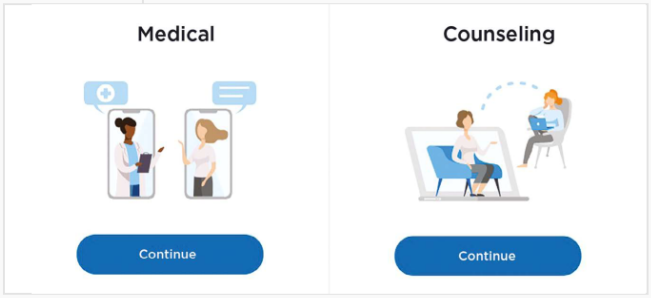
1.
Access MDLIVE by logging into **myCigna.com**® or by using the **myCigna**® **App**.

2.
Find the "Talk to a Doctor" button on the homepage. You may have to scroll down.

3.
Select the type of virtual care you need – Medical or Counseling. Estimated cost will be shown.[6]

4.
Schedule your appointment or start your visit today.





Visit myCigna.com or **call MDLIVE at 888.726.3171** when you need virtual care.

1. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older.
2. Appointments are required. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.
5. E-Treatment care is available in U.S. states, except Kansas, Mississippi, New Mexico, West Virginia, and the District of Columbia.
6. Prices shown on myCigna are not a guarantee. Coverage falls under your plan terms and conditions.

Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.

In California: Services may be available on an in-person basis or via telehealth from the enrollee's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with California law. Enrollees that have coverage for out-of-network benefits may receive services either via telehealth or on an in-person basis using the enrollee's out-of-network benefits. Note: out-of-network benefits, if available, will generally include higher out-of-pocket financial responsibility and no balance-billing protections. Please refer to your benefit plan documents for specific information about your benefit plan and out-of-network benefits.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Express Scripts, Inc., or their affiliates. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

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2027 Medical Plans Contributions

Per Pay Period (24)

(Bi-Weekly deductions)

Standard Rates

Payroll Contributions	OAP HDHP HSA $4,000-20%	OAP $2000 – 10%	OAP $0-0%
Employee Only	$92.50	$148.99	$343.29
Employee + Spouse	$261.24	$523.64	$851.27
Employee + Child(ren)	$231.56	$295.47	$726.26
Family	$477.44	$891.25	$1,150.55

Wellness Rates – NEW this year, to receive the wellness rate while enrolling your spouse/domestic partner, your spouse/domestic partner must have completed an annual physical between 10/1/25 and 9/30/26.

Payroll Contributions	OAP HDHP HSA $4,000-20%	OAP $2000 – 10%	OAPIN $0-0%
Employee Only	$0.00	$47.55	$219.32
Employee + Spouse	$126.57	$411.46	$716.87
Employee + Child(ren)	$108.01	$182.58	$591.86
Family	$342.01	$778.29	$1,016.15

NOTE: Bi-weekly payroll deductions do not cover all expenses such as copays and deductibles.

Imputed Income will be added to employee earnings for employees who provide healthcare to domestic partners and children over the age of 25.

Wellness Program Information

To qualify for the lowest possible medical plan rates in 2027, employees, and their spouses, if enrolled in one of the ECI Cigna medical plans, must complete an annual physical with their Primary Care Provider (PCP), General Practitioner, Internist, or Family Medicine doctor. This preventive wellness checkup helps lower your monthly premium contribution by placing you in the less expensive "Wellness Tier" of medical insurance.

Annual Physical Requirement for Wellness Discount

Important Dates

- For 2027, you and your spouse, if enrolling in one of the Cigna medical plans, have 30 days from hire to upload documents showing you had a physical between 10/1/25 and 9/30/26.
- For 2028, make sure you and your spouse, if enrolled in one of the medical plans, get one between 10/1/26 and 9/30/27.

Who Needs to Participate?

- For 2027, if you and your spouse (as a dependent) are going to be enrolled on the medical plan, you both will need to have completed an annual physical in 2026 for you to receive the “Wellness Tier” rate. This applies to any Qualifying Life Events.

How to Confirm Your Physical Was Completed?

- If your physical was completed by one of the Keiser/Everglades plans, your visit will be automatically verified.
- If completed outside of the Cigna medical plans offered by Keiser/Everglades (including other insurance carriers or the VA), you must submit the proof of completion, by providing your Explanation of Benefits (EOB) in the “HERE” link below.
- For VA visits, an attestation form and verification of DD-214 (we do not request/collect copies of DD-214) will be required stating that you received the annual physical exam at the VA.

Scheduling Your Physical

Confirm with your provider that the appointment is for a preventive annual physical exam. This cannot be an annual OB/GYN exam, or any other type of wellness exam; only full physicals done with a PCP, Internist, General Practitioner, or Family doctor will be accepted.

Additional Information

- Annual preventive checkups are free.

Submit your documentation HERE

For Questions Contact

Health Advocate: 866-799-2728 **Benefits@KeiserUniversity.edu**

CanaRx

Convenient home delivery for eligible brand-name maintenance medications

CanaRx is a prescription savings and convenience program available to eligible employees and members enrolled through Everglades College, Inc. The program is designed to help you access select brand-name maintenance medications at zero copay, with no shipping or handling charges. Medications are shipped directly to your door through a licensed pharmacy, making refills simple, safe, and easy to manage.

How it works

1. Check medication availability to see if your prescription is included in the CANARX program.
2. Enroll online or complete the downloadable enrollment form.
3. Submit your prescription by mail or ask your prescriber to fax it directly.
4. Receive your medication from a licensed pharmacy shipped straight to you.
5. Refills are managed for you. CanaRx will contact you before each refill so you can maintain a continuous supply.

Why use CANARX

- Zero copays for member copayments covered under this program
- No shipping or handling fees
- Home delivery for added convenience
- Simple refill process
- Safe, licensed pharmacy fulfillment
- Potential savings on select brand-name medications

What you'll need to enroll

To get started, have the following ready:

- A list of your current medications
- A photo ID
- A prescription for a 3-month supply with 3 refills
- Your prescriber's fax or mailing information, if needed

You may also be able to complete the enrollment using a downloadable form available in English and Spanish.

Important notes

CanaRx is a voluntary program and does not replace your regular prescription benefit plan. It is available for select brand-name maintenance medications listed on the CANARX formulary. Some medications are not included, such as:

- Controlled substances
- Medications requiring refrigeration
- Time-sensitive prescriptions, such as antibiotics
- Certain medications not on the formulary

If you are unsure whether a medication qualifies, you should check the formulary or contact CanaRx before enrolling.

Need help?

More information, a full FAQ, and enrollment details are available on the CanaRx website http://www.canarx.com/plan/?planid=ECI. You can also find plan-specific guidance and support there if you have questions about eligibility, medication availability, or the enrollment process.

Enroll today and start receiving convenient, cost-effective medications delivered right to your door.

Additional Ways to Save

Outside of an HSA, there are additional ways for you to save on health care expenses and stay on budget.

Look into discount drug programs offered by local pharmacies	
Pharmacy	**Offer**
Walmart	30-day supply starting at $4 | 90-day supply starting at $10

Research brand name drug rebates online	
Website	**Offer**
www.needymeds.org	Find help with the cost of medicine
www.gskforyou.com	Help with GSK medications and vaccines for qualified patients
www.rxpharmacycoupons.com	Search for drug coupons to use at your local pharmacy
www.goodrx.com	Compare Rx prices, print free coupons and save on your meds
www.internetdrugcoupons.com	Hundreds of free manufacturer drug coupons

Use freestanding Surgical and Diagnostic Centers when possible	
Ambulatory Services	Save on a covered surgery by having it done at an in-network, non-hospital-affiliated ambulatory surgical center.
Freestanding Diagnostic Centers	Save on MRIs, CAT scans, X-rays, etc. by having them done at participating freestanding diagnostic centers.

Save time and money when you choose the right level of care

$

Convenience Clinic

Use for preventive care services and common colds when your doctor is not available. This is a low-cost option

$$

Urgent Care

Use for immediate attention for non-threatening situations. Getting care will cost less than the ER and is generally quicker.

$$$

Emergency Room

Use for life-threatening injuries, as ERs are best suited for medical emergencies. ER follow-ups are not covered so it is best to schedule with your PCP for a follow-up visit.

Hinge Health

Hinge Health's Full Digital Musculoskeletal Clinic (Full DMC), with members routed to the program that best fits their needs after completing the enrollment questionnaire. Care pathways include acute, chronic, prevention, surgery (pre- and post-), and Women's Pelvic Health.

Eligibility

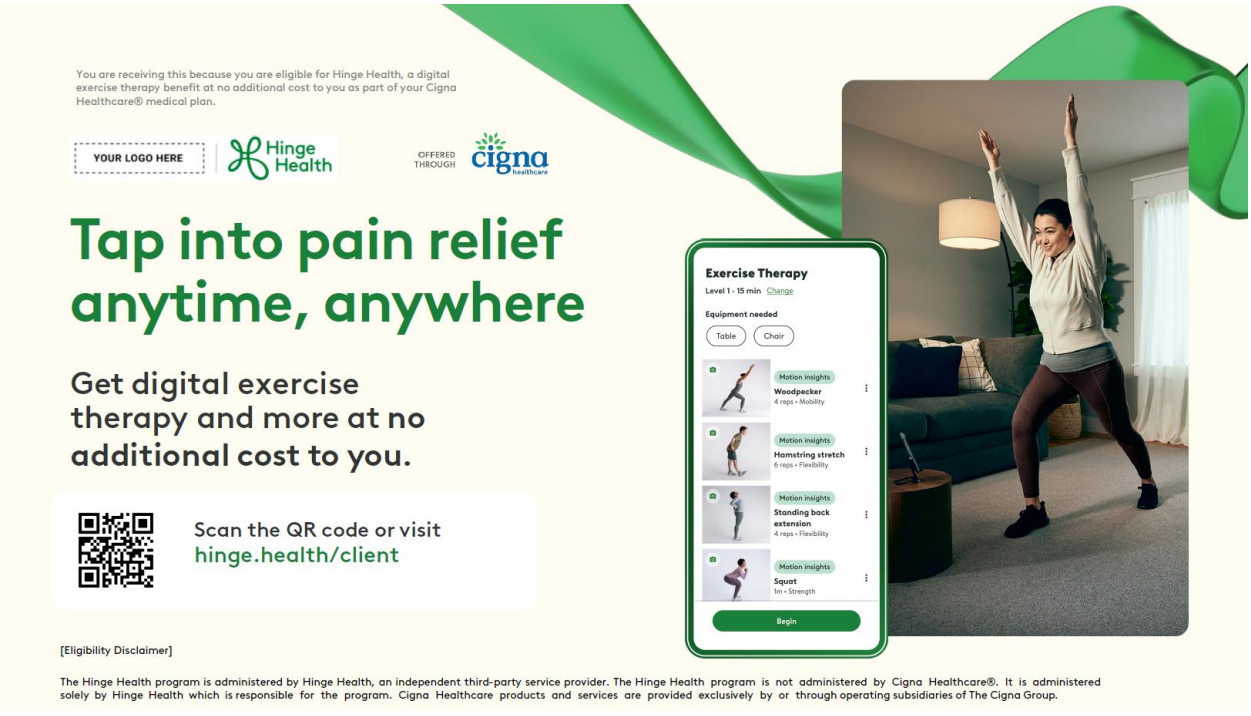
Employees, spouses, and dependents age 18 and older who are enrolled in a Cigna medical plan through Everglades College are eligible.

Enrollment

To enroll you can go to: hinge.health/evergladescollege

Member Support

Members can visit https://www.hingehealth.com/for-members/support/, email help@hingehealth.com, or call **855-902-2777** for help with enrollment, eligibility, application status, or app access.



GAP Plan

Gap insurance is a group supplemental medical product designed to provide benefits that cover certain out-of-pocket expenses as a result of medical treatment. It is paired with the employer's medical plan based on the medical deductibles available to the employees. Everglades College Inc. dba Keiser University & Everglades University is proud to offer four GAP insurance plans through Fidelity Security Life Insurance Company (claims should be filed through Amwins).

The primary difference between the plans is the amount of coverage you get. Please see your summary of benefits of coverage for a more detailed description of both plans.

If you elect the HDHP Plan with an HSA, you are not eligible to enroll in a Gap plan.

GAP	GAP $500/$500	GAP $1,000/$500	GAP $2,500/$500	GAP $2,500/$2,000
Individual Benefit Family Benefit	$500 $1,500	$1,000 $3,000	$2,500 $7,500	$2,500 $7,500
Inpatient Services	Up to $500	Up to $1,000	Up to $2,500	Up to $2,500
Inpatient/In-Hospital Maximum Benefit for all covered persons combined	$1,500	$3,000	$7,500	$7,500
Outpatient Services	Up to $500	Up to $500	Up to $500	Up to $2,000
○ Emergency Room	Included	Included	Included	Included
○ Urgent Care	Included	Included	Included	Included
○ Outpatient Surgery	Included	Included	Included	Included
○ Physical Therapy	Included	Included	Included	Included
○ Treatment for Mental Health	Included	Included	Included	Included

Contributions per Pay Period				
Employee Only	$12.45	$13.29	$17.58	$25.25
Employee + Spouse	$26.06	$27.84	$36.82	$52.90
Employee + Child(ren)	$21.65	$23.13	$30.60	$43.98
Family	$33.14	$35.41	$46.83	$67.29

- Claims can be submitted via email (helpme@webtpa.com)
- Paper claims can be mailed to Administrative Office: WebTPA P.O. Box 99906 Grapevine, TX 76099-9706.
- Claims submitted by a member, rather than Provider, will require a cover sheet of claim form and Explanation of Benefits (EOB). Claim forms can be found on the member portal (www.webtpa.com) and in PlanSource.

Health Advocate

Health Advocate is available to help you, and your family members understand and navigate the Healthcare system.

Health Advocate services are completely confidential and available to you, your spouse, dependents, parents, and parents-in-law, with the first 4 visits per calendar year at no cost.

- How Can Health Advocate Help You?
- Find In-Network Doctors
- Get Cost Estimates for Services
- Schedule Appointments
- Transfer Medical Records
- Facilitate Access to Care
- Answer Medicare Questions
- Resolve Insurance Claims
- Work with Insurance Carriers

Three Keys to Health Advocate

1. **It's easy to contact:**

   Call: 1-866-799-2728

   Email: answers@HealthAdvocate.com

   Visit: www.healthadvocate.com

2. **It's there when you need it.** There is no limit to the number of times you can contact Health Advocate for assistance.

3. **It's completely confidential.** Health Advocate's staff of Personal Health Advocates, Medical Directors, and administrative experts follow careful protocols. The staff is fully trained to follow government privacy standards. Your information is not shared with Everglades College Inc. dba Keiser University & Everglades University.



Dental Plans

Everglades College Inc. dba Keiser University & Everglades University offers four **Cigna** Dental Plans:

- A Dental Preferred Provider Organization (DPPO) High Plan
- A Dental Preferred Provider Organization (DPPO) Mid Plan
- A Dental Preferred Provider Organization (DPPO) Low Plan
- A Dental Health Maintenance Organization (DHMO) plan

We have included an explanation of each plan below. The next page provides plan highlights and your contributions.

DPPO Plan: The DPPO plan gives you the freedom to receive dental care from any licensed dentist of your choice. You will receive the highest level of benefit from the plan if you select an in-network contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in- and out-of-network services.

DHMO Plan: If you decide to enroll in the DHMO plan, please keep in mind that you and your enrolled dependents will need to select a primary care dentist who participates in the plan's network. To receive benefits in the DHMO plan, your primary care dentist must provide your dental care or refer you to a specialist for services. If you receive services outside of these requirements, you would be responsible for paying the entire dental bill yourself. Please refer to your primary care dentist's Patient Charge Schedule for procedures and applicable copays. A DHMO plan provides you with an unlimited benefit maximum.

NOTE: Finding a Provider: Visit http://www.cigna.com and click "Find a Doctor, Dentist or facility."
- For DPPO plans: Search on *Total DPPO Network*
- For DHMO plan: Search on *Access Network*



Dental Plans

PLAN HIGHLIGHTS	DPPO High Plan	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$5,000 per member	
Calendar Year Deductible (DED)		
Individual Family	$50 $150	$50 $150
Preventive Services		
Exams	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Cleanings (2 per calendar year)	Plan pays 100%, DED waived	Plan pays 100%, DED waived
X-Rays	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Basic Services		
Fillings (anterior/posterior)	Plan pays 100% after DED	Plan pays 100% after DED
Surgical Extractions	Plan pays 100% after DED	Plan pays 100% after DED
Root Canal	Plan pays 100% after DED	Plan pays 100% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 60% after DED	Plan pays 60% after DED
Implants	Plan pays 60% after DED	Plan pays 60% after DED
Orthodontics (Child up to age 19)		
Comprehensive	50%; $1,500 Lifetime Maximum	
Contributions per Pay Period		
Employee Only	$31.26	
Employee + Spouse	$62.09	
Employee + Child(ren)	$78.69	
Family	$119.35	

Dental Plans

PLAN HIGHLIGHTS	DPPO Mid Plan	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$5,000 per member	$5,000 per member
Calendar Year Deductible (DED)		
Individual Family	$50 $150	$100 $300
Preventive Services		
Exams	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Cleanings (2 per calendar year)	Plan pays 100%, DED waived	Plan pays 100%, DED waived
X-Rays	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Basic Services		
Fillings (anterior/posterior)	Plan pays 100% after DED	Plan pays 80% after DED
Surgical Extractions	Plan pays 100% after DED	Plan pays 80% after DED
Root Canal	Plan pays 100% after DED	Plan pays 80% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 60% after DED	Plan pays 60% after DED
Implants	Plan pays 60% after DED	Plan pays 60% after DED
Orthodontics (Child up to age 19)		
Comprehensive	50%; $1,500 Lifetime Maximum	
Contributions per Pay Period		
Employee Only	$27.78	
Employee + Spouse	$60.49	
Employee + Child(ren)	$64.19	
Family	$115.42	

Dental Plans

PLAN HIGHLIGHTS	DPPO Low Plan	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$1,000 per member	
Calendar Year Deductible (DED)		
Individual / Family	$100 / $300	$100 / $300
Preventive Services		
Exams	Plan pays 80%, DED waived	Plan pays 80%, DED waived
Cleanings (2 per calendar year)	Plan pays 80%, DED waived	Plan pays 80%, DED waived
X-Rays	Plan pays 80%, DED waived	Plan pays 80%, DED waived
Basic Services		
Fillings (anterior/posterior)	Plan pays 80% after DED	Plan pays 80% after DED
Surgical Extractions	Plan pays 80% after DED	Plan pays 80% after DED
Root Canal	Plan pays 80% after DED	Plan pays 80% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 50% after DED	Plan pays 50% after DED
Implants	Plan pays 50% after DED	Plan pays 50% after DED
Orthodontics (Child up to age 19)		
Comprehensive	Not Covered	
Contributions per Pay Period		
Employee Only	$17.90	
Employee + Spouse	$33.95	
Employee + Child(ren)	$41.36	
Family	$48.76	

PLAN HIGHLIGHTS	DHMO
Routine Cleanings (Code 1110/1120) Once every 6 months	No charge/$15 copay for additional within 6 months
Routine X-Rays	No charge
Resin Based – Posterior One Surface (Code 2391)	$47 copay
Endodontic therapy / Root Canal – Molar (Code 3330)	$335 copay, excludes final restoration
Orthodontics	
Pre-orthodontic treatment examination to monitor growth and development 8660/8999	$67 / $195 copay
Comprehensive Treatment: Child/Adult 8080/8090	$2,040 / $2,376 copay
Retention 8680	$345 copay
Contributions per Pay Period	
Employee Only	$6.48
Employee + Spouse	$11.65
Employee + Child(ren)	$15.27
Family	$22.29

Note: *This plan is not offered in the following states: Alaska, Maine, Montana, New Hampshire, New Mexico, North Dakota, South Dakota, Vermont, Wyoming, Puerto Rico, US Virgin Islands, Guam.*

Vision Plan

You can receive the following vision benefits when enrolled in **Cigna's Vision** plan, services by EyeMed:

- Every 12 months, **Cigna** covers your eye exam and either lenses *or* contact lenses
- Every 12 months, **Cigna** covers your frames

NOTE: You can search for providers by visiting http://www.cigna.com and clicking "Find a Vision Provider" and entering your search criteria.

Below are the plan highlights and your contributions.

PLAN HIGHLIGHTS	Vision	
	In-Network	Out-of-Network
Exam *1 every 12 months*	$10 Copay	Up to $40 Allowance
Lenses *1 every 12 months*		
Single	$15 Copay	Up to $40 Allowance
Bifocal	$15 Copay	Up to $60 Allowance
Trifocal	$15 Copay	Up to $80 Allowance
Frames *1 every 12 months*	$150 Allowance, then 20% off remaining balance	Up to $45 Allowance
Contact Lenses[1] *1 every 12 months*		
Elective	$120 allowance	Up to $120 Allowance
Medically Necessary	Covered in Full	Up to $210 Allowance
Contributions per Pay Period		
Employee Only	$2.62	
Employee + Spouse	$5.25	
Employee + Child(ren)	$5.30	
Employee + Family	$8.45	

[1]In lieu of eyeglass benefits

Health Savings Account (HSA)

If you participate in our High Deductible Health Plan (HDHP), you may be eligible to open a Health Savings Account (HSA). An HSA allows you to make tax-free contributions and earn tax-free growth of interest or investment earnings. You can use these contributions to pay for eligible expenses, such as medical and pharmacy expenses. Please refer to IRS publication 502 for a full list of eligible expenses.

Everglades College Inc. dba Keiser University & Everglades University is contributing $240 annually for an individual or $480 annually for family, the annual amounts are prorated ($10 per pay period for an individual / $20 per pay period for family). According to treasury regulations, you are allowed to revoke or change your HSA contribution election throughout the year. Any unused funds in your HSA will roll over annually. Additionally, your account is portable, which allows you to take your funds with you from job to job or at retirement.

Important! The IRS allows an annual maximum contribution to your HSA. Below are the annual maximum contributions for 2027.

	2027
Single	$4,500
Family	$9,000
Catch Up provision if age 55 or Older	$1,000

To be eligible to contribute into an HSA account, you cannot:

- Be covered by any other non-HSA-compatible health coverage plan including, but not limited to, a Traditional Medical FSA or an HRA held by a spouse or partner.
- Be claimed as a dependent on another person's tax return (excluding spouses).
- Be "entitled" (enrolled in) to Medicare (A, B, C, or D).
    - Be aware – if you delay Medicare Part A enrollment after turning age 65, your Medicare Part A coverage will begin up to 6 months retroactively but not earlier than Medicare eligibility.
    - Receiving Social Security benefits causes automatic Medicare Part A enrollment when eligible.
- Have prior year FSA dollars carryover / rollover into a current year general purpose FSA.
- Have a positive general purpose FSA grace period balance.

Frequently Asked Questions

How do I contribute to my HSA? You can make a contribution to your HSA through payroll deduction by requesting that your employer deduct a set amount from your paycheck.

When can I start to use the funds in my HSA? Once your account is open and you have available funds from a personal or company contribution, you can start using your HSA for eligible expenses. As soon as funds are deposited, you are 100 percent vested and in control of the funds.

What happens to my HSA if I leave my employer? You can keep your current HSA or transfer your funds to another qualifying HSA. If you choose to transfer your funds to a new HSA, you should complete the transfer within 60 days of withdrawing the funds in order to avoid taxes and an additional 20 percent penalty.

NOTE: you must be enrolled in an HDHP to continue to contribute to your HSA.
Please consult your tax professional for any personal tax advice.

Flexible Spending Accounts (FSA)

If you choose not to participate in an HSA or have chosen a plan that does not allow you to open an HSA, you may be eligible to open a Flexible Spending Account(s) (FSA) through a Section 125 plan. An FSA is a tax-free account in your name that pays or reimburses you for qualified health care or dependent care expenses, like medical and dental. You can make FSA contributions pretax through payroll, meaning that no employment or federal income taxes are deducted.

When you receive funds from your FSA, the reimbursements are also tax-free.

Everglades College Inc. dba Keiser University & Everglades University uses the IRS' rollover option on the Healthcare FSA. By allowing the addition of this rollover option, if you have a balance in your 2026 Healthcare FSA you will be able to roll that balance over (up to the IRS' 2027 rollover maximum allowance) into the 2027 FSA plan year. The amount you are eligible to rollover will be added to your 2027 FSA plan year Healthcare FSA election and those funds can be used for any expenses incurred during the entire 2027 plan year.

TIP: Keep your receipts, as you will need to provide them to verify your expenses throughout the year.

FSA Type	Detail
Health Care Reimbursement FSA	• Maximum annual contribution is $3,500. The minimum contribution is $500. • Allows you to pay for eligible health care expenses not covered by your insurance. • Eligible expenses include medical, pharmacy, dental, and vision. See IRS publication 502 for a comprehensive list of eligible expenses. • Up to $700 of unused funds can be rolled over into the new plan year.
Dependent Care FSA	• Maximum annual contribution is $5,000 ($2,500 for a married individual filing taxes separately). • Allows you to use pretax dollars towards qualified dependent care; care must be provided by a qualified dependent care service, not a relative. See IRC Sections 21 and 129 for a comprehensive list of eligible expenses. • It can be used to pay for qualified childcare expenses for dependent children under the age of 13 who live with you. • Can be used to pay for qualified caregiver expenses for a dependent (any age) who lives with you and is unable to care for themselves. • Care must be provided to keep you and your spouse gainfully employed. • At any given time, Dependent Care FSA distributions are limited to the amount you have in your account. Dependent care expenses cannot be reimbursed until they are actually incurred.

IMPORTANT!

- If eligible, you may elect to have multiple types of FSAs and contribute separate pretax dollar amounts to each.
- Your contributions are deducted from your paycheck in equal installments each pay period.
- "Use it or Lose It" – for Dependent Care FSA accounts, you own your account, but unlike HSAs, funds are not carried to the next plan year. You must use your contributions, or you will lose them at the end of the plan year.
- Under a Section 125 plan, participant elections generally must be irrevocable until the beginning of the next plan year. However, when a participant experiences one of several specific recognized events, he or she may be permitted to make a change in election that is consistent with the event.

For the plan year 2027, you have up until 3/31/2027 to file your eligible Healthcare and Dependent Care FSA expenses that were incurred during the 2026 plan year (01/01/2026 – 12/31/2026).

Voluntary & Additional Benefits



This section will review the following

- **Life and AD&D**
- **Disability**
- **Voluntary Benefits**

Life & AD&D

At. Everglades College Inc. dba Keiser University & Everglades University, you have two options for Life and AD&D insurance through **United Healthcare**:

Basic Life & AD&D Insurance – Employer Paid

In the event of a death, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Group Life & AD&D Insurance: As a full-time, benefits-eligible employee, you are eligible for Group Life & AD&D Insurance in the amount of $15,000 through **United Healthcare**. Age reduction applies; 65% at age 65 and to 50% at age 70 and will terminate at your retirement or as stated in the covered person termination of insurance, whichever occurs first.

Be sure to keep your beneficiary designations up to date! You can change your beneficiary designation at any time, even outside of the Open Enrollment period. You are also able to designate full payment to a sole beneficiary or payment percentages to multiple beneficiaries.

Voluntary Life & AD&D Insurance

In addition to the company-paid Life & AD&D Insurance, you can purchase additional coverage by enrolling in Voluntary Life & AD&D for yourself and your eligible dependents (such as spouses and children to age 25) through **United Healthcare**. In order to receive coverage for dependents, you must be enrolled in your own Voluntary Life and AD&D coverage. The Voluntary Life & AD&D insurance is convertible or portable for eligible individuals.

During this annual enrollment period, you can increase your coverage by one increment without Evidence of Insurability (EOI) as long as you do not go over the Guarantee Issue (GI) amount. This applies to both employees and spouses. If you go over the Guarantee Issue, then Evidence of Insurability will be required.

EMPLOYEE COVERAGE*	SPOUSE COVERAGE**	CHILD(REN) COVERAGE**
$25,000 increments to a maximum of the lesser of $500k or 5x annual earnings	$10,000 increments to a maximum of $100,000; cannot exceed 50% of Employee coverage	$10,000
Guarantee Issue: Lesser of 3X annual earnings or $300,000	*Guarantee Issue: $30,000*	*Guarantee Issue: $10,000*

Any amount of additional coverage requested may require an Evidence of Insurability ("EOI").

See the following page for cost breakdown.

Life & AD&D

MONTHLY COST OF COVERAGE - RATE PER $1,000 BENEFIT		
Age[1]	Employee	Spouse
<25	$0.031	$0.061
25-29	$0.031	$0.061
30-34	$0.040	$0.069
35-39	$0.057	$0.096
40-44	$0.083	$0.130
45-49	$0.120	$0.193
50-54	$0.190	$0.306
55-59	$0.295	$0.556
60-64	$0.405	$1.059
65-69	$0.668	$1.781
70-74	$1.136	$3.308
Child(ren)	$0.136	
Voluntary AD&D	EE & SP: $.016 / CH: $.048	

(1) Employee's rate is determined by the Employee's age. Spouse's rate is determined by the Employee's age.

** Your benefit will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.*

***Your dependent's insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. (Totally disabled means that, as a result of an injury, a sickness or a disorder, your dependent spouse is confined in a hospital or similar institution or is confined at home for sickness or injury; or has a life-threatening condition.)*

***Supplemental Life:** During the employer's scheduled Annual Enrollment Period, **an Employee who is insured for Supplemental Life** may increase coverage **by one incremental level ($25,000)** without providing proof of good health **up to the Guaranteed Issue limit of $300,000** as long as:*

- *Coverage had not been increased in the prior year due to a Family Status Change. An employee who is not insured for Supplemental Life is considered a late applicant and satisfactory proof of good health is required for any amount.*
- *An employee must submit satisfactory proof of good health for any increase in coverage over the Guarantee Issue limit.*
- *If an employee is already over the Guarantee Issue limit, an increase in coverage that is due solely to an increase in earnings will not require proof of good health unless the increased coverage is greater than a cumulative increase of $50,000 over the prior approved amount of Supplemental Life coverage.*

*During the employer's scheduled Annual Enrollment Period, **a Spouse who is insured for Supplemental Dependent Life** may increase coverage by **one incremental level** ($10,000) without providing proof of good health, **not to exceed the Guaranteed Issue limit of $30,000**. A Spouse over the Guarantee Issue limit must submit satisfactory proof of good health for any increase. A Spouse not insured for Supplemental Life is considered a late applicant and satisfactory proof of good health is required for any amount.*

***A Child** may elect coverage up to the Maximum Benefit of $10,000 with no proof of good health. However, the Employee must be approved prior to adding a child.*

To calculate your bi-weekly premium, find your age group in the left column and its coordinating rate in the right column. The rates shown are for each $1,000 of coverage, so you will need to take the total coverage amount elected and divide by $1,000. Once you have that number you will multiply that by the rate.

Example:

Age 31

Voluntary Life Rate is $0.040 + Voluntary AD&D Rate $0.016
Elects $50,000 life insurance coverage

$50,000 / $1,000 = 50
(0.040+0.016) X 50 = $2.80 monthly cost

$2.80 *12 / 24 = **$1.40 bi-weekly cost**

Disability

Disability insurance provides income protection in the event that you are unable to work due to a qualified disability.

Voluntary Short Term Disability (STD)

PLAN HIGHLIGHTS	LEVEL OF COVERAGE
Percentage of Wage Replacement	60% of covered weekly earnings
Maximum per Week	$3,500
Elimination Period	0 days for accident; 7 for sickness
Maximum Benefit Period	13 weeks

Voluntary Long-Term Disability (LTD)

Long-Term Disability Insurance with **United Healthcare** provides extended financial coverage if you are unable to work.

PLAN HIGHLIGHTS	LEVEL OF COVERAGE
Percentage of Wage Replacement	60% of covered monthly earnings
Maximum per Month	$10,000
Elimination Period	90 days
Maximum Benefit Period	Social Security Normal Retirement Age, as long as you meet the plans disability requirements

This information is not intended to be tax or legal advice. Specific questions about tax-related matters should be referred to your tax accountant, legal counsel, and the IRS.

Your benefit will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

***Pre-existing conditions may be exempt from coverage*

Voluntary STD and Voluntary LTD: Any elections past the initial new hire opportunity are considered late enrollees and require EOI approval for this enrollment period. Also, although an EOI is submitted and approved, the VSTD and VLTD are subject to the pre-existing condition exclusion as follows:

- *Voluntary STD – None*
- *Voluntary LTD – 3/12*

Voluntary Benefits

Critical Illness

- Insured through **UnitedHealthcare**
- Receive a cash benefit based on the percentage payable for a covered critical illness
- Coverage available for family members
- Benefits are paid directly to you at the time of the diagnosis
- You determine how to use the cash benefit
- The benefit premium increases with age, but your benefits do not decrease with age
- The benefit premium is based on plan option and benefit amount that you elect

Accident Protection

You can opt in to **United Healthcare**'s Accident Protection policy to cover accidents from motor vehicle collisions, sports injuries to everyday slips, and falls.

United Healthcare's policy may pay cash (based on a schedule) to help families offset the expenses associated with these accidents or injuries. Benefits may be paid for:

- Emergency room and doctor visit
- Follow-up and physical therapy visits
- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)

Hospital Indemnity

Unexpected hospital visits lead to unexpected costs – and research shows that most people aren't prepared to handle such surprise expenses. Hospital Indemnity Insurance can help cover some out-of-pocket medical costs associated with a hospital stay. This can be especially helpful if the major medical plan's deductible has not been met. Hospital Indemnity benefits are paid directly to the covered person, regardless of other coverage, and can be used for any purpose – there are no restrictions. This benefit is offered through **UnitedHealthcare**.

To receive payment for the wellness benefit for the Accident, Critical Illness, and Hospital Indemnity plan benefits, you will need to complete the UHC Wellness Benefit Claim Form and Instructions document (which can be found in the documents section in PlanSource) and file it with UHC so they can process and send you a check.

NOTE:
If enrolling after first eligible (1/1/2027 or as a new hire), pre-existing condition limitations may apply.

Critical Illness

UnitedHealthcare

Everglades College
Summary of Benefits: Critical Illness Protection
Plan Effective Date: 01/01/2027

Help protect yourself from costly medical expenses with UnitedHealthcare.

Critical Illness Protection Plan helps protect employees from costly expenses associated with the diagnosis of a serious illness. All benefits are paid directly to the insured and can be used towards any expense.

Your Critical Illness Protection Plan highlights:

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week. Employee must purchase coverage in order to purchase dependent coverage. Dependent children are covered to age 26.

Maximum Benefit Amount	Option A	Option B	Option C	Option D
Diagnosis of the covered condition must occur after insured is covered by the group contract; benefits are not payable for a diagnosis that occurs prior to the coverage effective date.				
Employee	$10,000	$20,000	$30,000	$40,000
Spouse	$10,000	$20,000	$30,000	$40,000
Child(ren)	$5,000	$10,000	$15,000	$20,000

Plan Provisions	
Reoccurrence Benefit**	Benefit payable for the same Covered Condition
Cancer Reoccurrence Benefit	Benefit payable for the same Cancer Condition category
Portability	Included

Covered Conditions *** Not eligible for the Reoccurence benefit*	Percentage of Insured's Maximum Benefit Amount Payable
Cancer Conditions	
Invasive Cancer	100%
Non-invasive Cancer	25%
Skin Cancer	$500
Vascular Conditions	
Coronary Artery Disease Minor (Stent or Angioplasty)	25%
Coronary Artery Disease Major (Bypass Surgery)	50%
Heart Attack	100%
Ruptured Aneurysm	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Organ Failure Conditions	
Bone Marrow Disease	100%
Chronic Renal Failure**	100%
Heart Failure**	100%
Major Organ Failure (Liver, Lung, Pancreas, Small Bowel)	100%
Functional Loss Conditions	

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Coma	100%
Loss of Hearing**	100%
Loss of Sight**	100%
Loss of Speech**	100%
Paralysis	100%
Severe Brain Damage	100%
Additional Conditions	
Addison's Disease**	25%
Benign Brain Tumor	100%
Crohn's Disease**	25%
Myasthenia Gravis**	25%
Severe Burns	100%
Systemic Lupus Erythematosus**	25%
Systemic Sclerosis (Scleroderma)**	25%
Childhood Disease Conditions**	
Cerebral Palsy	100% of Dependent Child Benefit
Childhood Diabetes	100% of Dependent Child Benefit
Cleft Lip / Palate	100% of Dependent Child Benefit
Congenital Heart Disease	100% of Dependent Child Benefit
Cystic Fibrosis	100% of Dependent Child Benefit
Down Syndrome	100% of Dependent Child Benefit
Muscular Dystrophy	100% of Dependent Child Benefit
Sickle Cell Anemia	100% of Dependent Child Benefit
Spina Bifida	100% of Dependent Child Benefit
Neurological Disease Conditions (diagnosis only)**	
Alzheimer's Disease	50%
Amyotrophic Lateral Sclerosis (ALS)	50%
Huntington's Disease	50%
Multiple Sclerosis	50%
Parkinson's Disease	50%
Advanced Neurological Disease Conditions (loss of ADLs)**	
Advanced Alzheimer's Disease	50%
Advanced Amyotrophic Lateral Sclerosis (ALS)	25%
Advanced Huntington's Disease	50%
Advanced Multiple Sclerosis	50%
Advanced Parkinson's Disease	50%
Occupational Conditions**	
Occupational Hepatitis	100%
Infectious Disease Conditions	
Coronavirus (COVID) with 3 day Hospitalization	$1,000

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Infectious Disease Minor (Diagnosis Only)*	25%
Infectious Disease Major (5 days Hospitalization)*	50%

**Cerebrospinal Meningitis (bacterial), Diphtheria, Encephalitis, Legionnaire's Disease, Lyme Disease, Malaria, Methicillin-Resistant Staphylococcus Aureus (MRSA), Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis, Rabies, Tetanus, Tuberculosis*

Additional Benefits	
Wellness Benefit	$75 Payable Once per calendar year per Insured

Wellness Benefit Covered Exams	
Antibody or Serology testing	Endoscopy
At-Home Screening tests for Colon Cancer	Fasting blood glucose test
Biopsy	Fasting plasma glucose (FPG)
Blood Test for Cholesterol	Flexible sigmoidoscopy
Blood test for triglycerides	Hemoccult stool analysis
Biometric Screenings	Hemoglobin A1C(HbA1c)
Bone Density scans	HPV Testing
Bone marrow testing	Lipid Panel
Breast ultrasound	Mammography
Breast MRI	Monoclonal Antibody Therapy
CA 15-3 (blood test for breast cancer)	Pap smear
CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
CEA (blood test for colon cancer)	Routine Physicals (through age 18)
Chest X-ray	Serum Protein Electrophoresis (blood test for myeloma)
Colonoscopy	Stress test on a bicycle or treadmill
Complete Blood Count	Thin prep pap test
Doppler screening for carotids	Thermography
Doppler screening for peripheral vascular disease	Serum cholesterol test to determine level of HDL and LDL
Doppler Screening for abdominal aorta	Virtual Colonoscopy
Echocardiogram	Routine Well-Child Exams (through age 18)
Electrocardiogram	Wellness Fair Screening

Benefit payable upon completion of a covered wellness exam or health screening test. One covered test per calendar year per Insured

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Critical Illness

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Frequently Asked Questions about your Critical Illness Protection Plan (CIPP)

Am I eligible for coverage?	You are eligible if you are working a minimum of 30 hours per week and considered benefit eligible by your employer.
What does Critical Illness Coverage provide me?	Critical Illness coverage provides protection against the expense of serious medical conditions.
Who pays for my Critical Illness coverage?	Your employer has made CIPP coverage available to all eligible employees on a voluntary basis, which means you pay your premiums if you elect the coverage.
When does my coverage go into effect?	You must be Actively at Work with your employer, as defined in your plan, on the date your coverage is scheduled to take effect. Otherwise, your coverage takes effect when you return to Active Work.
How do I cover a newborn child?	Newborn children are covered from the moment of live birth for the first 31 days. You would need to notify us within 31 days of the birth if you want to enroll that child, regardless of whether there are existing dependent children covered.
Can I receive a benefit for more than one of the covered conditions?	Each Covered Condition is payable at least one time for dates of diagnoses that occur while coverage is in force. Your Certificate of Coverage may require a separation period be met between the dates of diagnoses. *(Note: This is commonly referred to as additional occurrence.)*
If I have received a benefit for a covered condition (i.e., Heart Attack) and then get diagnosed again with that same condition, will another benefit be payable?	You may be eligible for another benefit payment for the **same** Covered Condition. This is referred to as Reoccurrence Benefit, and certain Conditions are eligible. Reoccurrence allows you to receive a benefit when: • You are diagnosed for a covered condition we have already paid a benefit for; • The diagnosis date of the reoccurrence is at least 180 Days following the previous date of diagnosis. Coverage must be in force on the date the reoccurrence is diagnosed. A second opinion or reconfirmation of a diagnosis is not considered reoccurrence.

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Is Cancer eligible for a reoccurrence benefit?	You may be eligible for another Cancer Condition benefit. This is referred to as Cancer Reoccurrence, and certain Cancer Conditions are eligible. Cancer Reoccurrence allows you to receive a benefit when: • You are diagnosed with a covered cancer condition we have already paid a benefit for; and • The diagnosis date of the cancer reoccurrence is at least 180 Days following the previous date of diagnosis; and Coverage must be in force on the date the cancer reoccurrence is diagnosed. A second opinion or reconfirmation of a diagnosis is not considered a cancer reoccurrence diagnosis
What constitutes a Cancer Reoccurrence vs an additional occurrence of cancer?	We have 3 distinct categories of Cancer Covered Conditions: • Invasive • Non-Invasive • Skin A diagnosis of cancer from the **same** Cancer Covered Condition "category" would be considered a Cancer Reoccurrence. (i.e. Invasive Cancer → Invasive Cancer). A diagnosis of cancer from a **different** Cancer Covered Condition "category" would be considered an additional occurrence. (i.e. Invasive Cancer → Non-Invasive Cancer).
What is considered "active treatment" when you look at no treatment for a Cancer reoccurrence benefit?	Active Treatment for Cancer means consultation, care or services provided by a Physician while Cancer is present. This includes diagnostic measures and taking prescription medications Active Treatment for Cancer does not include maintenance drug therapy or routine follow-up office visits, including testing or surveillance imaging.
I suffered a heart attack before I elected the Critical Illness Protection Plan. Would I be eligible for a benefit?	We do not pay for events that occurred before the effective date of coverage. However, if a subsequent diagnosis of that condition were to occur while coverage is in effect, a benefit may be payable.

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If a diagnosis of a Child Only Covered Condition is made during pregnancy, would we be eligible to receive a benefit for that condition if I choose to cover them as a dependent?	Dependent Children are eligible for coverage from the moment of live birth. If the diagnosis occurs prior to birth, that condition would be payable provided the child survives to live birth and becomes insured as a dependent child.
I enrolled my 5 year old child, who was diagnosed at birth with one of the Child Only Covered conditions. Would we be eligible to receive a benefit for that condition?	For a condition to be payable, coverage must be in force on the date of diagnosis. Therefore, in this situation, because diagnosis was made prior to the coverage effective date, a benefit would not be payable.

Other Important Details:

This Summary of Benefits sheet is an overview of the coverage being offered and is provided for illustrative purposes only. This is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

If you need to file a claim:

- Contact the employer
- Complete, sign and date the necessary forms.
- Send the completed forms via fax or mail to the contact details listed on the claim form. You may also email the completed forms to fpcustomersupport@uhc.com.

Exclusions and Limitations*:
We will not pay a benefit for a Critical Illness contributed to or caused by:

1. intentional self-inflicted Injury, this exclusion does not apply to the Mental Health Disorder Hospital Confinement Benefit if covered under this Policy;
2. attempted suicide, this exclusion does not apply to the Mental Health Disorder Hospital Confinement Benefit if covered under this Policy;
3. active participation in a riot, felony, assault, or illegal occupation;
4. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
5. loss sustained while on active duty as a member of the armed forces of any nation except during any time period insurance is extended under the Continuation during Leave of Absence provision;
6. Intoxication or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for You [or Your Dependents] by a Physician and taken as prescribed

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We also will not pay a benefit for a Critical Illness:

1. for which the Covered Person's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;
2. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

**The above list is intended for illustrative purposes only. State specific exclusions and language may apply. Please refer to your Certificate of Coverage for detailed information.*

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Critical Illness Cost Summary
****Attention plan sponsor – see sold UAF for benefit administration plan set up.****

Premiums shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here. *Please consult your human resources/benefits department for additional cost information.*

Estimated premiums shown below are based on the employee's age and tobacco status. Spouse age and tobacco status are based on Employee age and tobacco status.

Employee Paid Monthly Premium	Option 1: EE $10,000/ SP $10,000/ CH $5,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$4.40	$7.00	$4.40	$7.00
25-29	$5.10	$8.30	$5.10	$8.30
30-34	$5.90	$9.80	$5.90	$9.80
35-39	$7.10	$12.10	$7.10	$12.10
40-44	$9.20	$16.40	$9.20	$16.40
45-49	$12.70	$23.80	$12.70	$23.80
50-54	$17.50	$34.70	$17.50	$34.70
55-59	$23.30	$47.50	$23.30	$47.50
60-64	$33.20	$66.60	$33.20	$66.60
65-69	$43.40	$88.80	$43.40	$88.80
70-74	$61.20	$120.80	$61.20	$120.80
75+	$82.60	$159.10	$82.60	$159.10

Employee Paid Monthly Premium	Option 2: EE $20,000/ SP $20,000/ CH $10,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$8.80	$14.00	$8.80	$14.00
25-29	$10.20	$16.60	$10.20	$16.60
30-34	$11.80	$19.60	$11.80	$19.60
35-39	$14.20	$24.20	$14.20	$24.20
40-44	$18.40	$32.80	$18.40	$32.80
45-49	$25.40	$47.60	$25.40	$47.60
50-54	$35.00	$69.40	$35.00	$69.40
55-59	$46.60	$95.00	$46.60	$95.00
60-64	$66.40	$133.20	$66.40	$133.20
65-69	$86.80	$177.60	$86.80	$177.60
70-74	$122.40	$241.60	$122.40	$241.60
75+	$165.20	$318.20	$165.20	$318.20

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Employee Paid Monthly Premium	Option 3: EE $30,000/ SP $30,000/ CH $15,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$13.20	$21.00	$13.20	$21.00
25-29	$15.30	$24.90	$15.30	$24.90
30-34	$17.70	$29.40	$17.70	$29.40
35-39	$21.30	$36.30	$21.30	$36.30
40-44	$27.60	$49.20	$27.60	$49.20
45-49	$38.10	$71.40	$38.10	$71.40
50-54	$52.50	$104.10	$52.50	$104.10
55-59	$69.90	$142.50	$69.90	$142.50
60-64	$99.60	$199.80	$99.60	$199.80
65-69	$130.20	$266.40	$130.20	$266.40
70-74	$183.60	$362.40	$183.60	$362.40
75+	$247.80	$477.30	$247.80	$477.30

Employee Paid Monthly Premium	Option 4: EE $40,000/ SP $40,000/ CH $20,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$17.60	$28.00	$17.60	$28.00
25-29	$20.40	$33.20	$20.40	$33.20
30-34	$23.60	$39.20	$23.60	$39.20
35-39	$28.40	$48.40	$28.40	$48.40
40-44	$36.80	$65.60	$36.80	$65.60
45-49	$50.80	$95.20	$50.80	$95.20
50-54	$70.00	$138.80	$70.00	$138.80
55-59	$93.20	$190.00	$93.20	$190.00
60-64	$132.80	$266.40	$132.80	$266.40
65-69	$173.60	$355.20	$173.60	$355.20
70-74	$244.80	$483.20	$244.80	$483.20
75+	$330.40	$636.40	$330.40	$636.40

***Cost Includes Wellness Benefit**

UnitedHealthcare Critical Illness product is provided by United Healthcare Insurance Company on form UHICI-POL-1 et al., in Texas on UHICI-POL-1 and in Virginia on UHICI-POL-1-VA. Critical Illness coverage is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the mandate to have health insurance coverage. Failure to have other health insurance coverage may be subject to a tax penalty. Please consult a tax advisor. The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT.

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Accident Protection

UnitedHealthcare

Everglades College
Summary of Benefits: Accident Protection Plan
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Help protect yourself from the unexpected cost of an accident with UnitedHealthcare.

The Accident Protection Plan helps protect employees from costly expenses associated with an accident. All benefits are paid directly to the insured and can be used towards any expense.

Your Accident Protection Plan highlights:

Class 1 - All Active Full Time Employees working a minimum of 30 hours per week

Benefits Payable*	Maximum Amount Payable per Insured		
**All Benefits are payable once per covered accident unless otherwise noted*			
Accidental Death & Dismemberment (Spouse Benefit is 100% of EE; Child benefit 50% of EE)			
Death & Dismemberment			
- Life	$40,000	$40,000	$80,000
- Both hands or both feet	$40,000	$40,000	$80,000
- One hand and one foot	$40,000	$40,000	$80,000
- One hand or one foot	$20,000	$20,000	$40,000
- Two or more fingers or toes	$8,000	$8,000	$16,000
- One finger or one toe	$4,000	$4,000	$8,000
Common Carrier			
- Life	$160,000	$160,000	$320,000
Initial Care			
Ground Ambulance	$200	$300	$400
Air Ambulance	$1,250	$1,750	$2,250
Emergency Room Treatment	$180	$230	$330
Physician Office/Urgent Care *(1 per covered accident)*	$200	$200	$200
Hospital Care			
Hospital Admission *(1 per covered accident)*	$1,750	$2,250	$3,250
Hospital Confinement *(up to 365 days per year; starting Day 2 of Confinement)*	$350	$500	$700
Hospital ICU Admission *(1 per covered accident)*	$3,500	$4,500	$6,500
Hospital ICU Confinement *(up to 30 days per year; starting Day 2 of Confinement)*	$600	$800	$1,200
Follow Up Care			
Appliances Benefit			
- Wheelchair	$150	$225	$300

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- Knee Scooter	$150	$225	$300
- Knee Immobilizer	$150	$225	$300
- Lumbar Spine Brace	$150	$225	$300
- Walking Boot	$100	$150	$200
- Walker	$100	$150	$200
- Crutches	$100	$150	$200
- Leg Brace	$100	$150	$200
- Cervical Collar	$100	$150	$200
- Cane	$50	$75	$100
- Ankle Brace	$50	$75	$100
- Ankle Boot	$50	$75	$100
- Air Cast	$50	$75	$100
Follow up Physician Visit *(5 per covered accident)*	$85	$85	$85
Major Diagnostic Exam *(1 per plan year)*			
- MRI; CT; PET; EEG; ImPACT; or SPECT scan	$175	$250	$325
Minor Diagnostic Exam *(1 per plan year)*			
- X-ray; or a laboratory test	$50	$75	$100
Prosthetic			
- One Device	$1,200	$1,500	$1,850
- Two or More Devices	$2,400	$3,000	$3,700
Rehabilitation Facility *(per day up to 30 days)*	$100	$150	$200
Rehabilitation Therapy *(per visit up to 10 Visits; includes physical therapy, occupational therapy, speech therapy)*	$35	$45	$55
Common Injuries			
Abdominal/Thoracic Surgery			
- Surgery to repair	$1,000	$1,500	$2,000
- Exploratory without repair	$100	$150	$200
Arthroscopic Surgery	$200	$300	$400
Cranial Surgery	$200	$300	$400
Eye Surgery			
- Removal of foreign body	$210	$310	$400
- Surgical Repair	$210	$310	$400
Hernia Surgery	$250	$300	$400
Non-Specific Surgery			
- General Anesthesia	$210	$310	$410
- Conscious Sedation	$100	$150	$200
Tendon / Ligament / Shoulder Cartilage / Rotator Cuff / Knee Cartilage Surgery			

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- Surgery to repair one	$1,050	$1,550	$2,000
- Surgery to repair more than one	$1,200	$1,800	$2,400
- Exploratory without repair	$150	$225	$300
Blood/Plasma/Platelets	$630	$930	$1,230
Burns			
- 2nd Degree (at least 36% of body surface)	$1,525	$2,000	$2,000
- 3rd Degree (9 to 34 sq. inches)	$3,050	$4,000	$4,000
- 3rd Degree (35 or more sq. inches)	$12,200	$16,000	$22,000
- Skin Graft pays 25% of burn benefit			
Coma	$10,000	$15,000	$21,000
Concussion	$275	$375	$500
Dislocations	**Surgically Corrected/Non-Surgically Corrected**		
- Hip	$4,500 / $2,250	$6,300 / $3,150	$9,000 / $4,500
- Knee Cap (Patella)	$2,250 / $1,125	$3,150 / $1,575	$4,500 / $2,250
- Ankle	$1,500 / $750	$2,100 / $1,050	$3,000 / $1,500
- Foot (except toes)	$1,500 / $750	$2,100 / $1,050	$3,000 / $1,500
- Elbow	$900 / $450	$1,260 / $630	$1,800 / $900
- Collar Bone (Sternoclavicular)	$900 / $450	$1,260 / $630	$1,800 / $900
- Hand	$900 / $450	$1,260 / $630	$1,800 / $900
- Lower Jaw	$900 / $450	$1,260 / $630	$1,800 / $900
- Shoulder Blade	$900 / $450	$1,260 / $630	$1,800 / $900
- Wrist	$900 / $450	$1,260 / $630	$1,800 / $900
- Collar Bone (Acromioclavicular separation)	$500 / $250	$700 / $350	$1,000 / $500
- Finger	$500 / $250	$700 / $350	$1,000 / $500
- Toe	$500 / $250	$700 / $350	$1,000 / $500
Emergency Dental Work			
- Crown(s)	$200	$300	$600
- Extraction(s)	$100	$150	$200
Family Child Daycare	$30	$45	$60
- per day up to 30 days per covered accident			
Fractures	**Surgically Corrected/Non-Surgically Corrected**		
	Chip Fractures: 25% of the Non-Surgically Corrected Amount		
- Skull (Depressed, except bones of face or nose)	$4,500 / $2,250	$7,500 / $3,750	$10,000 / $5,000
- Sternum	$4,500 / $2,250	$7,500 / $3,750	$10,000 / $5,000
- Hip, Thigh (Femur)	$4,500 / $2,250	$7,500 / $3,750	$10,000 / $5,000

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- Skull (Simple, except bones of face or nose)	$2,500 / $1,250	$4,165 / $2,085	$5,555 / $2,780
- Leg (from top of tibia to ankle joint)	$2,500 / $1,250	$4,165 / $2,085	$5,000 / $2,500
- Pelvis (Excluding Coccyx)	$2,500 / $1,250	$4,165 / $2,085	$5,000 / $2,500
- Vertebrae (body of)	$2,500 / $1,250	$4,165 / $2,085	$5,000 / $2,500
- Sacral Sacrum	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Face or Nose (except teeth)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Upper Arm (Elbow to Shoulder)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Upper Jaw (except Alveolar process)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Ankle	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Foot (except Toes)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Forearm, Hand, Wrist (except Fingers)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Kneecap	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Lower Jaw (except Alveolar process)	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Shoulder Blade or Collarbone	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Vertebral Process	$900 / $450	$1,500 / $750	$2,000 / $1,000
- Coccyx	$700 / $350	$1,165 / $585	$1,555 / $780
- Finger or Toe	$300 / $150	$500 / $250	$665 / $335
Lacerations			
- Not Requiring Sutures	$125	$125	$75
- Less Than 5 cm	$200	$200	$200
- 5 cm - 15 cm	$625	$625	$1,000
- Greater Than 15 cm	$1,665	$1,665	$1,200
Lodging	$150	$200	$250
- per day up to 30 days per covered accident for treatment more than 100 miles away			
Medical Supplies	$10	$20	$30
- Over-the-counter (1 time per plan year)			
Pain Management / Epidural	$125	$175	$275
Paralysis			
- Hemiplegia	$5,000	$7,500	$10,000
- Paraplegia	$10,500	$10,500	$10,500
- Quadriplegia	$10,500	$15,000	$20,000
Ruptured / Herniated Disc	$600	$900	$1,200
Transportation			
- 3 trips per covered accident for treatment more than 100	$200	$300	$400

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

UnitedHealthcare

Everglades College
Summary of Benefits: Accident Protection Plan
Plan Effective Date: 01/01/2027

miles away			
Organized Sporting Activity Injury			
Payable for all covered persons	Increases Follow Up Care and Common Injuries benefits by 25%		
Additional Benefits			
Automobile Modification	$1,200	$1,500	$1,850
Wellness *See Wellness Details page for covered exams*	$100		
Plan Provisions			

UnitedHealthcare

Accident Protection Plan Wellness Benefit for Everglades College

Effective Date: 01/01/2027

Class 1 - All Active Full Time Employees working a minimum of 30 hours per week

Wellness Benefits Covered Exams
Blood test for triglycerides
Bone marrow testing
Breast ultrasound
CA 15-3 (blood test for breast cancer)
CA 125 (blood test for ovarian cancer)
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Fasting blood glucose test
Flexible sigmoidoscopy
Hemoccult stool analysis
Mammography
Pap smear
PSA (blood test for prostate cancer)
Serum Protein Electrophoresis (blood test for myeloma)
Serum cholesterol test to determine level of HDL and LDL
Stress test on a bicycle or treadmill
Thermography
Virtual Colonoscopy

Benefit paid upon completion of a covered wellness exam or health screening test. One covered test per plan year per Employee and Spouse

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Accident Protection

UnitedHealthcare

Everglades College
Summary of Benefits: Accident Protection Plan
Plan Effective Date: 01/01/2027

Frequently Asked Questions about your Accident Protection Plan (APP)

Am I eligible for coverage?	You are eligible if you are working a minimum of working a minimum of 30 hours per week and considered benefit eligible by your employer.
What does Accident Coverage provide me?	Accident coverage helps to provide financial protection against the unexpected expense of a covered accident.
What is considered an accident?	An Accident is an unforeseen event that occurs suddenly as the result of trauma and results in bodily injury. For a benefit to be payable, the accident must occur while coverage is in force.
Who pays for my coverage?	Your employer has made coverage available to all eligible employees on a voluntary basis, which means you pay your premiums if you elect the coverage.
When does my coverage go into effect?	You must be Actively at Work with your employer, as defined in your plan, on the date your coverage is scheduled to take effect. Otherwise, your coverage takes effect when you return to Active Work.
Can I keep my coverage if I leave my employer?	See your HR Representative or your Certificate of Coverage for your specific provisions. Your Employer will provide the initial paperwork. May be available for spouse and children when the employee elects . You can continue all or a portion of your Accident insurance. Evidence of Insurability is not required. Must apply and pay premium within 31 days of termination of your Accident insurance. Some state variations may apply.
Can I receive a benefit for more than one accident per plan year?	Yes. Benefits are payable per accident, regardless of the number of accidents that occur.
I had an accident that resulted in a broken leg before I elected the Accident Protection Plan and am still seeing my doctor and undergoing physical therapy. Would I be eligible for any of the benefits on the plan?	For a benefit to be payable, coverage must be in force on the date of the accident. Therefore, in this situation, because the accident occurred prior to the coverage effective date, a benefit would not be payable.

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Accident Protection

UnitedHealthcare

Everglades College
Summary of Benefits: Accident Protection Plan
Plan Effective Date: 01/01/2027

Other Important Details:

This Summary of Benefits sheet is an overview of the coverage being offered and is provided for illustrative purposes only. This is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

If you need to file a claim:

- Contact the employer.
- Complete, sign and date the necessary forms.
- Send the completed forms via fax or mail to the contact details listed on the claim form. You may also email the completed forms to fpcustomersupport@uhc.com.

Exclusions and Limitations*

We will not pay a benefit for a loss contributed to or caused by:

1. disease, bodily or mental infirmity, or medical or surgical Treatment of these (except pyogenic infections through an Accidental wound);
2. suicide or intentionally self-inflicted Injury;
3. active participation in a riot;
4. committing or attempting to commit a crime, or participating or attempting to participate in a crime;
5. taking part in the commission of an assault or being engaged in an illegal activity;
6. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
7. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for You by a Physician and taken as prescribed;
8. driving or in physical control of a Motor Vehicle while Intoxicated;
9. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping or using off-road vehicles that are not registered for use on-road based on applicable state law;
10. riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
11. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
12. travel or flight in, or descent from any aircraft, except if employment duties require You to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
13. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received; or
14. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule;

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

UnitedHealthcare

Everglades College
Summary of Benefits: Accident Protection Plan
Plan Effective Date: 01/01/2027

15. an Accident that occurs outside of the United States.

In addition to the exclusions shown above, no payment will be made for Treatment received outside of the United States.

**The above list is intended for illustrative purposes only. State specific exclusions and language may apply. Please refer to your Certificate of Coverage for detailed information.*

Accident Protection Plan Cost Summary

Monthly Rates	Voluntary *		
Quoted Rates - Per Employee Per Month	Option A	Option B	Option C
Employee Only	$10.45	$12.39	$15.25
Employee & Spouse	$16.69	$19.80	$24.35
Employee & Children	$16.94	$21.07	$27.30
Employee & Spouse & Children	$27.33	$33.63	$43.07

*Cost Includes Wellness Benefit

UnitedHealthcare Accident Protection product is provided by UnitedHealthcare Insurance Company on form UHI-ACC-POL (2018) et al., in Texas on form UHI-ACC-POL-TX (2018) and in Virginia on form UHI-ACC-POL-VA (2018). The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT.

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Hospital Indemnity

UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity
Protection Plan
Plan Effective Date: 01/01/2027

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Hospital Indemnity

UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity Protection Plan
Plan Effective Date: 01/01/2027

Help protect yourself from the high costs of hospital care with UnitedHealthcare.

Hospital Indemnity Protection Plan helps protect employees from costly hospital expenses. All benefits are paid directly to the insured and can be used towards any expense.

Your Hospital Indemnity Protection Plan highlights:

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week.

Plan Benefits	Benefit Amount Option A	Benefit Amount Option B
Hospital Admission *Payable for Injury or sickness, on the day of admission.* ***(up to 3 times per plan year)***	$1,100	$1,600
Hospital Confinement *Payable once per day of confinement for an injury or sickness, beginning on day 2.* ***(up to 364 Days per plan year)***	$100	$150
ICU Confinement *Payable once per day of confinement for an injury or sickness, beginning on day 2.* ***(up to 364 Days per plan year)*** *Payable in addition to Hospital Confinement.*	$100	$150
ICU Admission *Payable for Injury or sickness, on the day of admission.* ***(up to 3 times per plan year)*** *Payable in addition to Hospital Admission*	$1,100	$1,600
Inpatient Drug & Alcohol *Payable once per day. Lifetime maximum is 300 days* ***(up to 30 Days per plan year)***	$100	$150
Inpatient Mental & Nervous Disorder *Payable once per day. Lifetime maximum is 300 days.* ***(up to 30 Days per plan year)***	$100	$150

This benefit summary is an overview of your insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Hospital Indemnity

UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity
Protection Plan
Plan Effective Date: 01/01/2027

Additional Benefits	Benefit Amount Option A	Benefit Amount Option B
Wellness Benefit	$50	$50

Wellness Benefits Covered Exams
Blood test for triglycerides
Bone marrow testing
Breast ultrasound
CA 15-3 (blood test for breast cancer)
CA 125 (blood test for ovarian cancer)
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Fasting blood glucose test
Flexible sigmoidoscopy
Hemoccult stool analysis
Mammography
Pap smear
PSA (blood test for prostate cancer)
Serum Protein Electrophoresis (blood test for myeloma)
Serum cholesterol test to determine level of HDL and LDL
Stress test on a bicycle or treadmill
Thermography
Virtual Colonoscopy

Benefit paid upon completion of a covered wellness exam or health screening test. One covered test per calendar year per covered member. Children are excluded from Wellness

This benefit summary is an overview of your insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Hospital Indemnity

UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity Protection Plan
Plan Effective Date: 01/01/2027

Frequently Asked Questions about your Hospital Indemnity Protection Plan (HIPP)

What does HIPP Coverage provide me?	Hospital Indemnity coverage provides protection against the expense of hospital care as a result of an illness or injury.
Who pays for my Hospital Indemnity coverage?	Your employer has made HIPP coverage available to all eligible employees on a voluntary basis, which means you pay your premiums if you elect the coverage. You may also have the option to purchase coverage for your Spouse or Child.
Am I eligible for coverage?	You are eligible if you are working a minimum of 30 hours per week and considered benefit eligible by your employer.
When does my coverage go into effect?	You must be Actively at Work with your employer, as defined in your plan, on the date your coverage is scheduled to take effect. Otherwise, your coverage takes effect when you return to Active Work.
Is pregnancy covered under my HIPP plan?	Yes, hospitalization for routine labor and delivery is included with your HIPP coverage. Complications of Pregnancy are covered to the same extent as any other sickness.
How do I cover a newborn child?	Newborn children are covered from the moment of live birth for the first 31 days. You would need to notify us within 31 days of the birth if you want to enroll that child, regardless of whether there are existing dependent children covered.
Is newborn/nursery care covered under my HIPP plan?	A newborn child's routine nursing or routine well baby care is not included. If the newborn is admitted and confined to the hospital due to complications, it would be covered as any other sickness.
Are Confinement benefits payable on the day I am admitted to the hospital or ICU?	Confinement benefits begin on the day following admission. For a confinement benefit to be payable, a room and board charge must be incurred for that day.

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UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity Protection Plan
Plan Effective Date: 01/01/2027

If I am admitted to the ICU will I also get the Hospital Admission benefit?	Each covered person may receive 3 Days Hospital and 3 Days ICU Admission benefit per plan year. If a covered person is admitted to the ICU, and has not exhausted their Hospital Admission benefit, the Hospital Admission benefit would be payable in addition to the ICU Admission benefit.
If I am confined to the ICU will I also get the Hospital Confinement benefit for those days?	Each covered person may receive benefits for up to 364 Days of confinement in a Hospital and up to 364 Days of confinement in ICU, per plan year. If a covered person is confined to the ICU, and has not exhausted their Hospital Confinement benefits, the Hospital Confinement benefit would be payable in addition to the ICU Confinement benefit.
Can I keep my HIPP coverage if I leave my employer?	Your policy contains the following. See your HR Representative or your Certificate of Coverage for your specific provisions. Your Employer will provide the initial paperwork. Portability • May be available for spouse and children when the employee elects portability. • You can continue all or a portion of your HIPP insurance. • Evidence of Insurability is not required. • Must apply and pay premium within 31 days of termination of your HIPP insurance.*

Other Important Details:

This Summary of Benefits sheet is an overview of the coverage being offered and is provided for illustrative purposes only. This is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

If you need to file a claim:

- Contact the employer
- Complete, sign and date the necessary forms.
- Send the completed forms via fax or mail to the contact details listed on the claim form. You may also email the completed forms to fpcustomersupport@uhc.com.

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UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity
Protection Plan
Plan Effective Date: 01/01/2027

Other Important Details:

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UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity
Protection Plan
Plan Effective Date: 01/01/2027

Exclusions and Limitations *:

This Policy does not cover any loss caused by or resulting from (directly or indirectly):

1. an act or Accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation [except during any time period coverage is extended under the Continuation during Leave of Absence provision];
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. taking part in the commission of an assault or being engaged in an illegal activity;
7. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
8. cosmetic or elective surgery; or
9. treatment received outside the United States or its territories;
10. the reversal of a tubal ligation or vasectomy;
11. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
12. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
13. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
14. driving in any organized or scheduled race or speed test or while testing an automobile or any
15. mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
16. dental or plastic surgery for Cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
17. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or renumeration is received

**The above list is intended for illustrative purposes only. State specific exclusions and language may apply. Please refer to your Certificate of Coverage for detailed information.*

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Hospital Indemnity

UnitedHealthcare

Everglades College
Summary of Benefits: Hospital Indemnity
Protection Plan
Plan Effective Date: 01/01/2027

Hospital Indemnity Cost Summary (Current Monthly rates)

Monthly Rates	Voluntary *	
Quoted Rates - Per Employee Per Month	Option A	Option B
Employee Only	$10.51	$14.97
Employee & Spouse	$20.96	$29.87
Employee & Children	$17.58	$25.35
Employee & Spouse & Children	$29.89	$42.99

*Cost Includes Wellness Benefit

UnitedHealthcare Hospital Indemnity product is provided by UnitedHealthcare Insurance Company on policy forms UHIHIP-POL-TX, et al. and UHIHIP-CERT-TX, et al. in Texas and UHIHIP-POL-VA, et al. and UHIHIP-CERT-VA, et al. in Virginia. The product provides a limited benefit for certain hospital indemnity plan benefits. Please note: HOSPITAL INDEMNITY coverage is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the mandate to have health insurance coverage. Failure to have other health insurance coverage may be subject to a tax penalty. Please consult a tax advisor. The policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. This product is not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT.

This benefit summary is an overview of your insurance. Once a group policy is issued to your employer, a Certificate of Coverage will be available to explain your benefits in detail. In the event of a conflict between this benefit summary and your Certificate of Coverage, the Certificate of Coverage will control.

Legal Plan

Protect Your Legal Rights with LegalShield

Legal matters are common and hiring an attorney can be expensive. LegalShield makes it affordable.

LegalShield is a licensed legal expense organization. Full service and representation on all types of legal services, including, but not limited to the below:

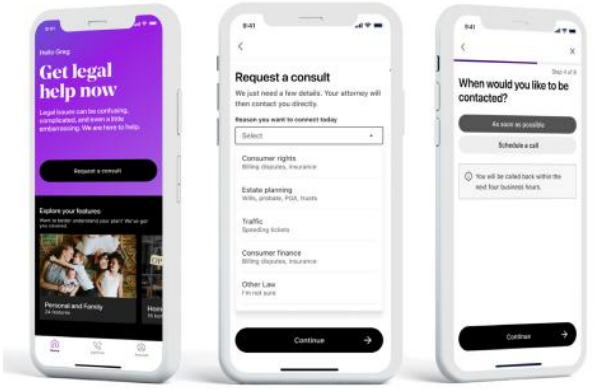
- Divorce
- Traffic tickets
- Buying or selling a home
- Foreclosures
- Will preparation
- Bankruptcy
- Garnishments criminal defense
- Lawsuits
- Child support, custody, and visitation
- And much more!

Your monthly cost for coverage is $15.75

LegalShield's mobile app puts a law firm in the palm of your hand

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"This is a **great service** and the **app is AMAZING**.
To have access to attorneys at your fingertips is such a comfort.
The app is really easy to navigate and makes it easy
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Beyond Med

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A membership program to enhance your most important investment: yourself.



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- **15** Specialties
- **2,500+** Offices
- **400+** Treatments

MEMBER PERKS

Curated Network
Access to thousands of elective and cosmetic providers at reduced rates

Concierge Service
A concierge team to guide you and an easy-to-use mobile application

Unlimited Savings
No waiting periods and no limits to benefit usage (use it as much as you want!)

SAVE ON SERVICES LIKE:

Acupuncture	Mental Wellness
Anti-Aging	Med Spa
Bariatric	Physical Therapy
Chiropractic	Plastic Surgery
Dermatology	Surgical Vision
Fertility	Vein Therapy
Hair Restoration	Veterinary
Hearing	Weight Loss

INDUSTRY'S LEADING PROVIDERS

IVFMD · NEW YORK BARIATRIC GROUP · SPORTSCARE PHYSICAL THERAPY · SILVER MIRROR FACIAL BAR · BOSLEY · RMA LONG ISLAND IVF · NEXT | HEALTH · TESSLER PLASTIC SURGERY · PROFESSIONAL PHYSICAL THERAPY · SKINNEY · SISU · HAIRCLUB

FOR MORE INFO, CONTACT US AT INFO@BEYONDMEDPLANS.COM or VISIT WWW.BEYONDMEDPLANS.COM

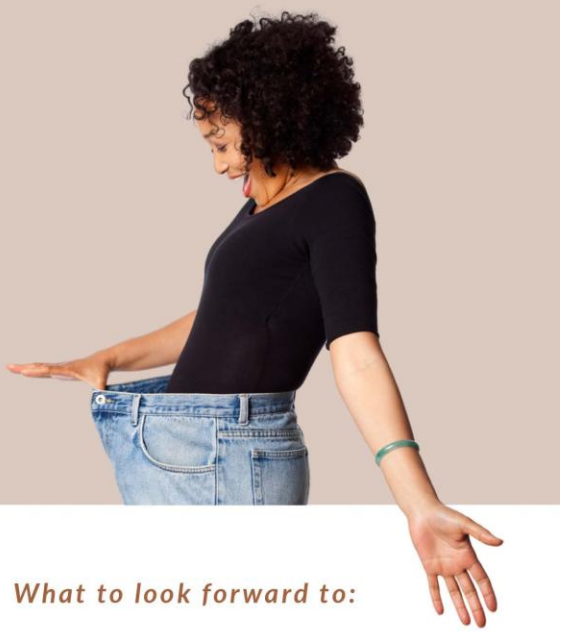
Beyond Med Plans Inc. ("BMP") is not insurance. BMP provides discounts at certain health care providers for medical services. BMP does not make payments directly to the providers of medical services. BMP members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with BMP. Beyond Med Plans Inc. is a licensed Discount Plan Organization which is administered from 3050 Biscayne Blvd. Suite 904, Miami, FL 33137.

Rates:
$12 Individuals /$24 Family coverage

Beyond Med

Beyond Med

We can't change your genes, but we **CAN** change your *jeans*



Ready to take the next step in your weight loss journey? If diet and exercise haven't delivered the results you hoped for, treatments like *Semaglutide* (active ingredient in Ozempic® and Wegovy®) or *Tirzepitide* (active ingredient in Mounjaro® and Zepbound®) can be game-changers for managing weight and blood sugar levels.

However, these innovative treatments often come with a high out-of-pocket cost, exceeding $1,000 a month. With Beyond Med, you can save 65-80% on your treatment, making it easier to access the care you need without the hefty price tag.

What to look forward to:

Consultation
Schedule an appointment with a participating provider and have your consultation at a Beyond Med network location or via telemedicine.

Telehealth
Utilize one of Beyond Med's affiliate telehealth platforms to engage in remote consultations and Rx delivery.

Lab Test
If you are eligible for the treatment, your healthcare provider may request a metabolic lab test.

Prescription
Your provider will determine the appropriate medication treatment. Our in-network providers can also help you manage your weight loss journey with nutrition and exercise, along with the medication.

[V] IVIM · NEW YORK BARIATRIC GROUP · CMWL the center for medical weight loss · RM RED MOUNTAIN WEIGHT LOSS · NH NEXT | HEALTH

Disclaimer: Semaglutide and Tirzepitide are prescription medications, and their use should be directed by a qualified healthcare provider. Individual results may vary, and potential side effects should be discussed with a healthcare professional. Out-of-pocket prices may vary depending on the provider. Please consult with your healthcare provider for specific details regarding costs and potential financial assistance options.

FOR MORE INFO, CONTACT US AT INFO@BEYONDMEDPLANS.COM or VISIT WWW.BEYONDMEDPLANS.COM

Beyond Med Plans Inc. ("BMP") is not insurance. BMP provides discounts at certain health care providers for medical services. BMP does not make payments directly to the providers of medical services. BMP members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with BMP. **Beyond Med Plans Inc. is a licensed Discount Plan Organization** which is administered from 3050 Biscayne Blvd. Suite 904, Miami, FL 33137.

Annual Notices



Medicare Part D Creditable Coverage Notice
Important Notice from EVERGLADES COLLEGE, INC.
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 EVERGLADES COLLEGE, INC. 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. **EVERGLADES COLLEGE, INC. has determined that the prescription drug coverage offered by the plan 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 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 while enrolled in EVERGLADES COLLEGE, INC. coverage as an active employee, please note that your EVERGLADES COLLEGE, INC. coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in EVERGLADES COLLEGE, INC. coverage as a former employee.

You may also choose to drop your EVERGLADES COLLEGE, INC. coverage. If you do decide to join a Medicare drug plan and drop your current EVERGLADES COLLEGE, INC. 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 [Insert Name of Entity] 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 EVERGLADES COLLEGE, INC. 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:	November 9, 2026
Name of Entity/Sender:	EVERGLADES COLLEGE, INC.
Contact-Position/Office:	Human Resources - Benefits Department
Address:	1900 W. Commercial Blvd., Suite 180, Fort Lauderdale, FL – 33309
Phone Number:	954-776-4476

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in EVERGLADES COLLEGE, INC.'s group health coverage 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 or any longer period that applies under the plan 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 or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan. To request special enrollment or obtain more information, contact:

Human Resources - Benefits Department
954-776-4476
Benefits@keiseruniversity.edu

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

New Health Insurance Marketplace 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 Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

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

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 Period3 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 your plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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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	**4. Employer Identification Number (EIN)**	
Everglades College Inc. dba Keiser University & Everglades University	65-0216638	
5. Employer address	**6. Employer phone number**	
1900 W. Commercial Blvd., Suite 180	954-776-4476	
7. City	**8. State**	**9. Zip code**
Fort Lauderdale	FL	33309

10. Who can we contact about employee health coverage at this job?

Human Resources - Benefits Department

11. Phone number (if different from above)	**12. Email address**
	Benefits@keiseruniversity.edu

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:
    - Employees working 30 or more hours per week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    - Spouse or domestic partner and children up to age 26 or 30, if they qualify
  - ☐ 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.

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, 2026. 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)	Website: Health Insurance Premium Payment (HIPP) Program 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: 1-800-766-9012

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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
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: (617) 886-8102 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: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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**
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 Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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, 2026, 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

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

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."

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;
- 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 or longer period permitted under the terms of the Plan, after the qualifying event occurs. You must provide this notice to the Plan Administrator.

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**.

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.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

Annual Notices

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.

Plan contact information
Name of Entity/Sender: Everglades College Inc. dba Keiser University & Everglades University
Contact-Position/Office: Human Resources - Benefits Department
Address: 1900 W. Commercial Blvd., Suite 180, Fort Lauderdale, FL – 33309
Phone Number: 954-776-4476





