# Augustana College

# 2026
# EMPLOYEE BENEFITS

**DISCLAIMER**

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by Augustana College. If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract. The information in this booklet is proprietary. Please do not copy or distribute to others.

**This booklet serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.**

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your Benefits Manager.

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This benefit summary describes the benefit plans available to you as an employee of Augustana. The details of these plans are contained in the official plan documents that have been provided to you. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

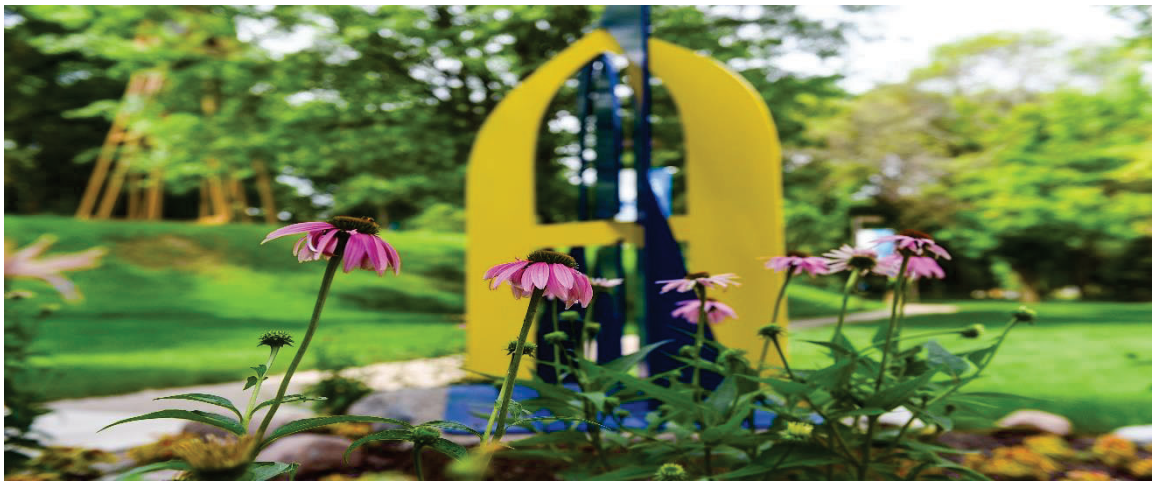
If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Augustana.

# BENEFITS CONTACT INFORMATION

## Got Questions? We've Got Answers!

Please refer to this list if you have questions about your benefits and you need to contact one of your benefit providers or Human Resources at Augustana College.

| Coverage | Contact | Website/Email | Phone |
|---|---|---|---|
| **Assistant Director of Human Resources** | Cristina Rios | cristinarios@augustana.edu | 309-794-7740 |
| **Health & Pharmacy Benefits** | UMR | https://member.umr.com/home | 800-826-9781 |
| **Pharmacy Benefits** | MedOne | https://members.medone-rx.com/ | 866-335-9057 |
| **Specialty & High-Cost Rx** | Sharx | https://sharxplan.com/members/ | 314-451-3555 |
| **Telemedicine** | Teledoc | www.teledoc.com | 800-835 3362(TELEDOC) |
| **Health Savings Account** | Quad City Bank & Trust | www.qcbt.com | (563) 388-7228 |
| **Flexible Spending Accounts** | Employee Benefits Corporation (EBC) | www.ebcflex.com | 1 (800) 346-2126 |
| **Dental** | MetLife | https://www.metlife.com/ | 800-638-5433 |
| **Vision** | MetLife | https://www.metlife.com/ | 800-638-5433 |
| **Life/ Long Term- Disability/Supplemental Life** Policy Number: 170657 | The Standard | www.Standard.com | 888-937-4783 |
| **Voluntary: Critical Illness/ Accident** Policy Number: 170657 | The Standard | www.Standard.com | 888-937-4783 |
| **Hospital Indemnity** Policy Number: 170657 | The Standard | www.standard.com | 888-937-4783 |
| **Employee Assistance Program** | AllOne Health | www.perspectivesltd.com | Call or Text 800-456-6327 |
| **Retirement** | TIAA- CREF | www.tiaa-cref.org/augustana | 1 (800) 842-2252 |



# WELCOME!

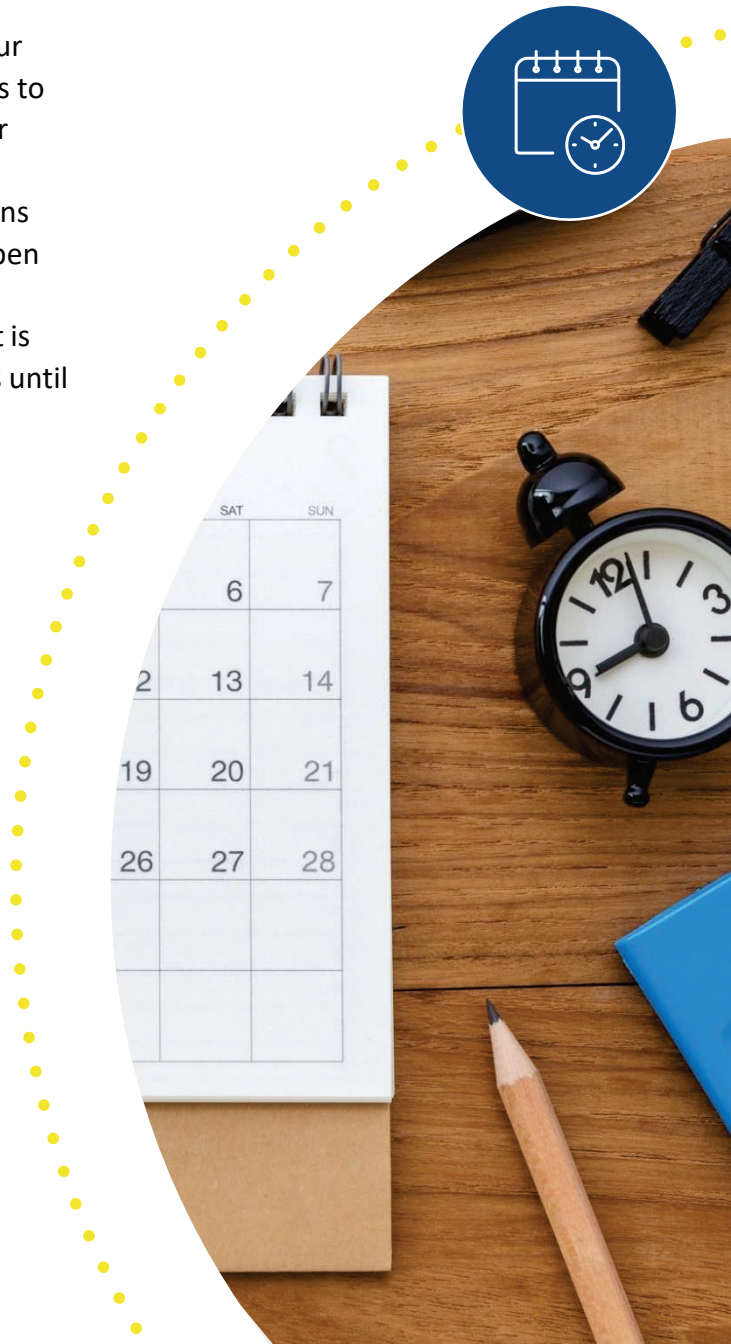
We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best. This benefits guide is designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

The following pages provide overview information on each of our benefit programs. Full summary plan description documents are available by contacting Human Resources. You can find monthly premium information for each benefit on pages 21 through 25.

## OPEN ENROLLMENT

***November 3, 2025 – November 14, 2025***

Open Enrollment takes place each fall and is your annual opportunity to review and make changes to your benefit elections for the following calendar year. This is an active enrollment, meaning all employees must log in and confirm your elections during the period. Changes made during this open enrollment will be effective from January 1 - December 31, 2026. Once the open enrollment is complete, you will not be able to make changes until the next open enrollment period unless you experience a Qualifying Life Event (QLE).




## QUALIFYING LIFE EVENTS

Your benefit elections made during Open Enrollment will be effective **January 1, 2026.** You may not make changes to your elections unless you experience a qualifying life event (QLE). QLEs include, but are not limited to, a change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or if you gain/lose coverage elsewhere.

### IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN **30** DAYS of the qualifying life change event.

Contact Cristina Rios, the Assistant Director of Human Resources, or login to Paycor to process a Qualifying Life Event.

# BENEFITS ELIGIBILITY

You and your eligible family members may participate in the 2026 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week. Employees working 20 -29 hours per week are eligible to participate in select benefit programs such as voluntary life insurance, and critical illness, accident or hospital indemnity insurance.

## NEW-HIRE ELIGIBILITY

New hires can join the plan the **first of the month following date of hire**. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

## DEPENDENT ELIGIBILITY

You can enroll the following dependents in our group benefit plans:

- Your legal spouse **or domestic partner**
- Children
    - A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
    - Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of disability status required)

UMR

## REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an account at https://member.umr.com/home to access time-saving tools, find tips for healthy living, choose a doctor, manage your EOBs, and more!

## DOWNLOAD THE MOBILE APP

With the UMR mobile app, you've got the tools you need to manage your healthcare from your smartphone. The mobile app is available in the Apple and Google Play stores.

# CHOOSE YOUR MEDICAL PLAN

Your medical plans will be offered through UMR. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

Elections you make during Open Enrollment will be effective **January 1, 2026** and remain in effect until **December 31, 2026** unless you experience a qualifying life event.

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lowest out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

# UNDERSTANDING YOUR PLAN

**1** **YOUR FAMILY** visits your provider (doctor/hospital) and shows their medical insurance card

**2** **YOUR DOCTOR OR PROVIDER** will bill your medical carrier

**3** **YOUR MEDICAL CARRIER** will process your claim, notify your provider, and send an Explanation of Benefits to you and your provider


**4** **YOUR RESPONSIBILITY** You are responsible to pay the amount due to your provider as shown on your EOB

# MEDICAL AND RX - TRADITIONAL PPO

## Medical – UMR Choice Plus Network

| BENEFIT OVERVIEW | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | | |
| Single | $2,000 | $4,000 |
| Family | $4,000 | $8,000 |
| Coinsurance | 20% | 50% |
| **Out-of-Pocket Maximum** | | |
| Single | $4,000 | $8,000 |
| Family | $8,000 | $16,000 |
| **BENEFIT HIGHLIGHTS** | | |
| Physician Visits | | |
| Primary Care | $35 | 50% after Deductible |
| Specialist Care | $80 | 50% after Deductible |
| Preventive Care | No Charge | 50% after Deductible |
| Urgent Care | 20% after Deductible | 50% after Deductible |
| Chiropractic Care | 20% after Deductible | 50% after Deductible |
| Telehealth Services | | |
| Teledoc | $0 | N/A |
| Hospital Services | | |
| Inpatient | 20% after Deductible | 50% after Deductible |
| Outpatient | 20% after Deductible | 50% after Deductible |
| Emergency Room | $200 Copay | |
| Mental Health / Substance Abuse Services | | |
| Inpatient | 20% after Deductible | 50% after Deductible |
| Outpatient | 20% after Deductible | 50% after Deductible |
| Office Visit | $35 | 50% after Deductible |

## Pharmacy – MedOne PremierOne Network, Access Formulary

| Prescription Drugs | In-Network | Out-of-Network |
|---|---|---|
| Tier 1 | $10 or 20% to $25 Maximum | $10 or 20% to $25 Maximum |
| Tier 2 | $30 or 30% to $75 Maximum | $30 or 30% to $75 Maximum |
| Tier 3 | $50 or 50% to $125 Maximum | $50 or 50% to $125 Maximum |

Deductible of $100/person or $300/family must be met for brand prescriptions.

**www.members.medone-rx.com**

# MEDICAL INSURANCE - HDHP

## Medical – UMR Choice Plus Network – HSA Eligible

| BENEFIT OVERVIEW | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | | |
| Single | $4,250 | $8,500 |
| Family | $8,500 | $17,000 |
| Coinsurance | 0% | 20% |
| **Out-of-Pocket Maximum** | | |
| Single | $4,250 | $8,500 |
| Family | $8,500 | $17,000 |
| **BENEFIT HIGHLIGHTS** | | |
| Physician Visit | | |
| Primary Care | 0% after Deductible | 20% after Deductible |
| Specialist Care | 0% after Deductible | 20% after Deductible |
| Preventive Care | No Charge | 20% after Deductible |
| Urgent Care | 0% after Deductible | 20% after Deductible |
| Chiropractic Care | 0% after Deductible | 20% after Deductible |
| Telehealth Services | | |
| Teledoc | No Charge | N/A |
| Hospital Services | | |
| Inpatient | 0% after Deductible | 20% after Deductible |
| Outpatient | 0% after Deductible | 20% after Deductible |
| Emergency Room | 0% after Deductible | Deductible |
| Mental Health / Substance Abuse Services | | |
| Inpatient | 0% after Deductible | 20% after Deductible |
| Outpatient | 0% after Deductible | 20% after Deductible |
| Office Visit | 0% after Deductible | 20% after Deductible |

## Pharmacy – MedOne PremierOne Network, Access Formulary

| Prescription Drugs | In-Network | Out-of-Network |
|---|---|---|
| Tier 1 | 0% after Deductible | 0% after Deductible |
| Tier 2 | 0% after Deductible | 0% after Deductible |
| Tier 3 | 0% after Deductible | 0% after Deductible |

# HEALTH AND PHARMACY BENEFITS

## 24/7 doctor visits via phone or mobile app

TELADOC.

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care, when you need it.

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone, video or mobile app
- Prompt treatment, median call back, in 10 minutes
- A network of doctors that can treat every member of the family
- Prescriptions sent to pharmacy of choice if medically necessary
- Teladoc is less expensive than the ER or urgent care

**Talk to a doctor anytime!**
visit **Teladoc.com**
or call
**1-800-Teladoc**

Google play

### Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

UMR

A UnitedHealthcare Company

# HEALTH AND PHARMACY BENEFITS

Teladoc HEALTH


## Big or small, there's help for whatever you're facing.

Your Teladoc Health Mental Health benefit gives you access to **therapy, mental health coaching** and **medication management**. You also get a library of **personalized content** to manage anything from stress and anxiety to substance use and grief. Get your personalized care plan today by completing a brief wellness assessment.

**Talk with a therapist or certified coach**
Work through challenges and set achievable goals for lasting change.

**Feel more relaxed**
Discover helpful calming techniques and build resilience to lower your stress.

**Improve your relationships**
Build healthier connections and keep loved ones close.

**Get helpful tools that work**
Manage mental health conditions, grief, LGBTQ+ challenges and more.

**Tip:**
Need to calm down in a hurry? Watch a funny video or write down three things that make you happy.

## Prioritize your mental health today

TeladocHealth.com | 1-800-835-2362
Download the app

# AUGUSTANA CONVENIENT CARE

**A partnership between MercyOne Genesis at Work and Augustana College**

**Augustana Convenient Care**
**Baldur House**
**3410 9 ½ Avenue**
**Rock Island**

**Hours**
**Monday- Friday 10:00am to 5:00pm**
**Saturday 9:00am to 1:00pm**

## SERVICES INCLUDE:

- Many Services are free and available to employees on the health plan
- Testing for COVID-19 and strep
- Flu Vaccinations
- Treatment of colds and flu, pneumonia, fever, sore throat, earache, conjunctivitis (pink eye), sinus and urinary tract infections.
- Treatment of rashes and insect bites, sprains, and minor fractures.
- Maintenance drug prescriptions and allergy shots

Augustana College

MERCYONE GENESIS

# HEALTH AND PHARMACY BENEFITS

**Sharx is our partner to fill prescriptions for individuals taking speciality or high cost ($350 or more) medications. Sharx must be used to fill these prescriptions. Sharx customer service will reach out to qualified participants.**

## WHO IS ELIGIBLE?

Your employer is making this program available to members enrolled in the health plan. If you are currently on a high-cost prescription medication, you will want to follow the steps below for potential cost savings to you! If you are eligible to participate in the SHARx program to lower drug costs for you and your family, follow the instructions in the welcome email or call 314-451-3555.

## WHAT ARE THE COSTS?

There are no costs to participate in the SHARx program. Your employer has paid 100% of the cost of this service for you and your family as long as you are enrolled in your employer's health plan. Prescriptions obtained through this service could be FREE for you and your family. Sometimes a co-pay or out of pocket amount will be required, but this out of pocket may be substantially less than what you are paying now.

## Instructions to Create Your Advocacy Request

If you have been identified as having a high-cost medication, you will receive a welcome email from SHARx.

After receiving the email, please follow the instructions in the email:

1. Click on the custom link in the email to create an account on the SHARx platform.
2. Validate your identity and set up a user account for the website.
3. After logging in, you can verify the prescription information we have on file for you (and your dependents).
4. Sign the HIPAA form and we'll get to work finding the best option for your medication(s).

If you do not receive a welcome email or are prescribed a high-cost medication in the future, please email sharx@sharxplan.com or call 314-451-3555.

# HEALTH SAVINGS ACCOUNT (HSA)

## Quad City Bank & Trust

### WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, coinsurance, prescriptions, vision, and dental expenses. High-deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- **Lower paycheck costs** — allowing you to keep control of more of your money
- **Tax-advantaged savings account** — enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs and reduces your taxable income
- **Comparable benefits** — these plans use the same networks that other plans offer, and in-network preventive care is still covered at 100%

### HOW MUCH CAN I CONTRIBUTE?

- Employee only coverage: **$4,400** calendar year
- Employee plus dependents coverage: **$8,750**
- If you are 55 or older, you can make an additional annual catch-up contribution of **$1,000**

### WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high-deductible health plan
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP
- Cannot be enrolled in a traditional health care FSA in the same calendar year
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare
- Cannot be claimed as a dependent on another person's tax return
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

### HSAs AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

**Note:** You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

# FLEXIBLE SPENDING ACCOUNT (FSA)

## Employee Benefits Corporation (EBC)

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

## HEALTH CARE FSA

**Who can participate?**

Employees who are not enrolled in the high-deductible health plan.

**What are the contribution limits?**

Employees can contribute up to $3,400 in 2026.

**What happens at the end of the year?**

The Health Care FSA allows a 2-1/2 month Grace Period: Expenses can be incurred through **3/15/27**

**WHAT'S AN ELIGIBLE EXPENSE?**

**Health Care FSA** – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

**Dependent Care FSA – Child day care, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.**

## DEPENDENT CARE FSA

**Who can participate?**
Any employee.

**What are the contribution limits?**
Employees can contribute up to **$7,500** annually per family or **$3,750** if filing separately.

**What happens at the end of the year?**
FSA funds expire at the end of each year. Use it or lose it. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

# DENTAL PLAN

## MetLife (PDP Plus Network)

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. You and your eligible dependents may enroll in one of the two dental coverage options administered by MetLife.

To find an in-network provider visit:
https://www.metlife.com/

| Coverage Features | In- Network | Out-Of-Network |
|---|---|---|
| **Annual Calendar Year Deductible – Individual** | $50 | $50 |
| **Annual Calendar Year Deductible – Family** | $150 | $150 |
| **Type A: Preventive Care** | 100% | 100% |
| **Type B: Basic Restorative** | 80% | 80% |
| **Type C: Major Restorative** | 50% | 50% |
| **Type D: Orthodontia Services** | 50% | 50% |
| **Annual Maximum Benefit- per Individual** | $1250 | $1250 |
| The annual maximum benefit applies to all covered services, including preventive, basic, and major care. | | |
| **Orthodontia Lifetime Maximum- Ortho applies to Child(ren) under 19 only** | $1,000 Per Person | $1,000 Per Person |
| **Dependent Age** | Eligible for benefits until the day the child turns 26 years old. | |

# VISION PLAN

## MetLife – VSP Network

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do these activities, however, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by MetLife and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. MetLife utilizes the VSP network.

| BENEFIT OVERVIEW | In-Network | Out-of-Network |
|---|---|---|
| EXAMS | | |
| Exam | $10 Copay | $45 Allowance |
| Routine Retinal Screening | Up to $39 Copay | Applied to the Exam Allowance |
| **FRAMES** | | |
| | $130 Allowance, 20% balance over allowance | $70 Allowance |
| **LENSES** | | |
| Standard Single Vision | $25 Copay | $30 Allowance |
| Lined Bifocal | $25 Copay | $50 Allowance |
| Lined Trifocal | $25 Copay | $65 Allowance |
| Standard Lenticular | $25 Copay | $100 Allowance |
| Additional lens enhancements available. See full plan document for details. | | |
| **CONTACT LENSES (in lieu of Lenses and Frame)** | | |
| Elective | $130 Allowance | $105 Allowance |
| Medically Necessary (Prior Authorization Required) | Covered in Full | $210 Allowance |
| **FREQUENCY** | | |
| Exams | 12 Months | |
| Frames | 24 Months | |
| Lenses | 12 Months | |

**To find an in-network provider please visit https://www.metlife.com/**

# EMPLOYEE ASSISTANCE PROGRAM

## AllOne Health

We understand that we all face serious problems at some time in our lives and Augustana is committed to providing help during those times.

The EAP is designed to assist staff members and families with personal challenges in many different areas including depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

Participation in the EAP is voluntary, confidential and free of cost. For those who require referrals for long-term treatment, there may be fees for the services of outside providers.

However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs.

Access AllOne Health Member Portal at

https://perspectives.mylifeexpert.com

Username: Augustana

# BASIC LIFE INSURANCE

## The Standard

### BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

The Basic Life and AD&D plan provides a benefit in the to help provide financial support and stability to your family should you pass away. This benefit is sponsored by Augustana so you will automatically be enrolled at no cost to you if you work 30 or more hours per week.

### BENEFITS

Your life coverage will be 1.5 times your annual earnings to a maximum of $400,000.

Your Accidental Death & Dismemberment coverage is the same as your life coverage. AD&D will pay a percentage of other covered losses per the plan document.

### LIFE AGE REDUCTIONS

Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65 and to 50 percent at age 70.

### OTHER BASIC SERVICES

- Accelerated Death Benefit
- Portability
- Conversion
- Travel Assistance

### BENEFICIARIES

Please be sure your beneficiary designations are up to date. Your beneficiary(ies) will be the person(s) you receive the payment in the event of your death.

# VOLUNTARY LIFE INSURANCE

## The Standard

You have the option of supplementing your employer-paid basic life insurance with voluntary life insurance for increased benefit amounts through payroll deductions. **Employees working 20 hours or more per week are eligible to elect Voluntary Life Insurance.**

### BENEFITS

- Employee: Up to $500,000 in increments of $10,000 – Guarantee Issue of up to $150,000 for new employees
- Spouse: Up to $250,000 in increments of $5,000 – Guarantee Issue of up to $30,000 for new employees
- Children (age 18 and younger): $10,000

Guaranteed Issue amounts are the amount of coverage you can purchase without having to complete Evidence of Insurability.

You may be required to provide Evidence of Insurability as part of the application process if you are electing coverage outside of your initial enrollment opportunity. This process may require you to complete a health questionnaire for your coverage to be approved.

### HOW MUCH COVERAGE TO PURCHASE?

Your benefits can be used to pay for

- Outstanding Debt
- Burial Expenses
- Medical Bills
- Child's education
- Daily expenses for your loved ones

To estimate your insurance needs, you'll need to consider your unique circumstances. An online calculator can be found at www.standard.com/life/needs

### OTHER BENEFITS

- Accelerated Death Benefit
- Travel Assistance
- Life Services Toolkit

### PREMIUM AMOUNTS

What your costs for coverage are depend on the benefit amount you choose and your age. Premiums are calculated based on the age you are as of January 1 of each year.

| Your Age | Your Rate % (per $1,000 of total Coverage) | Spouse's Age | Spouse's Rate % (per $1,000 of total Coverage) |
|---|---|---|---|
| < 25 | $0.06 | < 25 | $0.06 |
| 25-29 | $0.08 | 25-29 | $0.08 |
| 30-34 | $0.09 | 30-34 | $0.09 |
| 35-39 | $0.14 | 35-39 | $0.14 |
| 40-44 | $0.21 | 40-44 | $0.21 |
| 45-49 | $0.42 | 45-49 | $0.42 |
| 50-54 | $0.65 | 50-54 | $0.65 |
| 55-59 | $0.70 | 55-59 | $0.70 |
| 60-64 | $1.27 | 60-64 | $1.27 |
| 65-69 | $3.23 | 65-69 | $3.23 |
| 70-74 | $8.53 | 70-74 | $8.53 |
| 75+ | $17.07 | 75+ | $17.07 |
| Child(ren) Rate: $2.00 | | | |

**Use this formula to calculate your premium payment**

| _____ | ÷ 1000 = _____ | x_____ | = _____ | _____ |
|---|---|---|---|---|
| Enter the amount coverage you are requesting (see benefit amounts in the About This Coverage Section | | Enter your rate from the rate table. | This amount is an estimate of how much you would pay each month | To get a sense of your weekly premium, multiply premium amount by 12(months) and then divide by 52 (weeks) |

# ACCIDENT INSURANCE

## The Standard

Accident insurance pays out a lump sum if you become injured because of an accident — even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly. **Employees working 20 hours or more per week are eligible to elect Accident Insurance.**

### How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Benefit payments are not reduced by any other insurance you may have with other companies

**Covered expenses typically include:**

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

| Tier | Monthly Premium |
|---|---|
| Employee | $9.41 |
| Employee + Spouse | $14.95 |
| Employee + Child(ren) | $17.78 |
| Family | $27.85 |

Please refer to the summary plan description for a full details regarding benefit amounts.

# CRITICAL ILLNESS

## The Standard

While Medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery. **Employees working 20 hours or more per week are eligible to elect Critical Illness.**

### HOW WILL A CLAIM GET PAID?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used however you see fit.

### Covered Expenses Include:

Heart attacks, stroke, end stage renal failure, major organ failure, ALS, cancer, and more…

Premium is based on coverage amount elected, age, and tobacco use. Dependents under age 26 are automatically covered at 50% of the employee election amount at no cost. Please see the premium chart below.

**Employee Non-Tobacco Monthly Attained Age Premiums**

| Coverage Amount | Employee Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 18-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70+ |
| **$10,000** | $3.90 | $4.90 | $6.30 | $8.20 | $11.00 | $14.60 | $18.60 | $23.30 | $31.70 | $43.90 | $58.50 |
| **$20,000** | $7.80 | $9.80 | $12.60 | $16.40 | $22.00 | $29.20 | $37.20 | $46.60 | $63.40 | $87.80 | $117.00 |
| **$30,000** | $11.70 | $14.70 | $18.90 | $24.60 | $33.00 | $43.80 | $55.80 | $69.90 | $95.10 | $131.70 | $175.50 |

**Employee Tobacco Monthy Attained Age Premiums**

| Coverage Amount | Employee Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 18-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70+ |
| **$10,000** | $4.30 | $5.90 | $8.20 | $12.00 | $17.40 | $24.90 | $34.10 | $46.30 | $66.20 | $93.30 | $117.30 |
| **$20,000** | $8.60 | $11.80 | $16.40 | $24.00 | $34.80 | $49.80 | $68.20 | $92.60 | $132.40 | $186.60 | $234.60 |
| **$30,000** | $12.90 | $17.70 | $24.60 | $36.00 | $52.20 | $74.70 | $102.30 | $138.90 | $198.60 | $279.90 | $351.90 |

**Spouse Monthly Attained Age Premium - Based on Employee's Age and Non-Tobacco Status**

| Coverage Amount | Employee Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 18-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70+ |
| **$5,000** | $1.95 | $2.45 | $3.15 | $4.10 | $5.50 | $7.30 | $9.30 | $11.65 | $15.85 | $21.95 | $29.25 |
| **$10,000** | $3.90 | $4.90 | $6.30 | $8.20 | $11.00 | $14.60 | $18.60 | $23.30 | $31.70 | $43.90 | $58.50 |
| **$15,000** | $5.85 | $7.35 | $9.45 | $12.30 | $16.50 | $21.90 | $27.90 | $34.95 | $47.55 | $65.85 | $87.75 |

**Spouse Monthly Attained Age Premium - Based on Employee's Age and Tobacco Status**

| Coverage Amount | Employee Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 18-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70+ |
| **$5,000** | $2.15 | $2.95 | $4.10 | $6.00 | $8.70 | $12.45 | $17.05 | $23.15 | $33.10 | $46.65 | $58.65 |
| **$10,000** | $4.30 | $5.90 | $8.20 | $12.00 | $17.40 | $24.90 | $34.10 | $46.30 | $66.20 | $93.30 | $117.30 |
| **$15,000** | $6.45 | $8.85 | $12.30 | $18.00 | $26.10 | $37.35 | $51.15 | $69.45 | $99.30 | $139.95 | $175.95 |

Please refer to the summary plan description for a full details regarding benefit amounts.

# HOSPITAL INDEMNITY

## The Standard

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury. Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover. **Employees working 20 hours or more per week are eligible to elect Hospital Indemnity.**

### HOW DOES IT WORK?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness (minimum 20 hour stay), your Hospital Indemnity plan makes cash payments to you.You can use these funds to pay for costs not covered by your medical insurance, deductibles, copays and coinsurance, child-care expenses while you are in the hospital or cost-of- living expenses as you recover.

| PLAN DESIGN | BENEFIT |
|---|---|
| Hospital Confinement | $100/day (10 day max.) |
| Hospital Admission | $1,000/calendar year |
| Critical Care Unit<br>Pays in addition to Hospital Confinement | $100/day (10 day max.) |
| Health Maintenance Screening | $50 |
| Pre-Existing Condition Limitation | None |

Please refer to the summary plan description for a full details regarding benefit amounts.

| TIER | MONTHLY PREMIUM |
|---|---|
| Employee | $12.71 |
| Employee + Spouse | $21.83 |
| Employee + Child(ren) | $17.90 |
| Family | $31.90 |

# EMPLOYEE CONTRIBUTIONS

Rates illustrated below are monthly amounts

| Medical | Traditional PPO | HDHP |
|---|---|---|
| Employee | $203.75 | $153.13 |
| Employee + 1 | $540.75 | $395.13 |
| Family | $710.75 | $520.13 |

| Dental | Amount |
|---|---|
| Employee | $43.62 |
| Employee + 1 | $85.59 |
| Family | $158.18 |

| Vision | Amount |
|---|---|
| Employee | $6.93 |
| Employee + 1 | $12.49 |
| Family | $18.79 |

# DISABILITY INSURANCE

## The Standard

If you become disabled for an extended period of time and cannot work, no benefit becomes more important to your financial security than disability income protection. Augustana College provides a number of income protection benefits - at no cost to you.

## Life Event Pay

Life Event Pay is designed to support employees during times when a serious health condition prevents them from working or when they need to care for a family member with a serious health condition as defined by the Family and Medical Leave Act. After one year of service, eligible employees working at least 30 hours per week (or at least 18 credits) may receive up to 80 hours of Life Event Pay if eligible for Paid Time Off, or up to 160 hours if not. Life Event Pay may also be used for parental or bonding leave. To request Life Event Pay, contact the Human Resources department. Medical certification from a physician is required. This benefit runs concurrently with FMLA and other available paid leave.

## Short-Term Disability

The Short-Term Disability plan provides income protection if you become disabled and cannot work due to a non-work-related illness or injury. To be eligible, employees must have at least 6 months of service and work at least 30 hours per week (or at least 18 credits). The Short-Term Disability benefit begins to pay benefits after 14 days of continuous disability. This benefit replaces 60% of your regular weekly base pay and continues for up to 24 weeks. Medical certification from a physician is required. This benefit runs concurrently with FMLA and other available paid leave.

## Long-Term Disability

If you remain totally disabled and unable to work for more than 180 days, you may be eligible for Long-Term Disability (LTD) benefits through The Standard. LTD benefits replace up to 60% of your monthly pay, up to a maximum of $6,000 per month. Monthly LTD benefits will be reduced by Social Security and any other disability income you are eligible to receive. Please refer to the full benefit plan description for details. Medical certification from a physician is required. This benefit runs concurrently with FMLA.

# OTHER EMPLOYEE BENEFITS

## Education and Tuition Benefits

Augustana College is proud to support the educational goals of employees and their families through several tuition benefit programs, including Tuition Remission, the ELCA Tuition Exchange, and the Tuition Exchange Program. These benefits provide eligible employees, spouses, and qualifying children access to reduced or fully covered tuition at Augustana or participating institutions. To qualify, employees must work at least 20 hours per week or, for adjunct faculty, teach at least 14 credits per year. Each program has a its own eligibility and waiting period requirements -- typically two years for tuition remission and ELCA exchange, and four years for the national Tuition Exchange program. Cost, availability, and specific award levels vary by program and by participating school.

Employees are encouraged to attend infromational sessions offered annually by the Human Resources and Financial Aid departments. These sessions review details of these programs and outline application processes. You can learn more about tuition programs by reviewing the full policy in the Employee Handbook.

## Rivermont Collegiate Tuition Reduction

Employees of Augustana College are eligible to receive a reduction of tuition at Rivermont Collegiate. For updated pricing and discount rates, please call Rivermont Collegiate and identify yourself as an employee of Augustana College. Proof of employment, if needed, can be provided by the Office of Human Resources.

## Retirement Benefits

Planning for your future is one of the most important investments you can make - and Augustana College is proud to help you do it. Through our 403(b) Retirement Savings Plan, employees can build long-term financial security with the support of both personal contributions and generous college contributions. All employees are eligible to participate in the plan (with the exception of student employees and non-resident aliens with no U.S. earned income), giving you the flexibility to start saving for retirement right away.

Employees working 20 hours or more per week, or faculty teaching at least 14 credit hours, are eligible for college matching contributions immediately upon hire. **Augustana matches employee contributions dollar for dollar on the first 2% of pay contributed to the plan. After one year of service, eligible employees also receive an additional 5% college contribution, regardless of whether they contribute their own funds.** This means employees can receive up to 7% in total contributions from the college each year.

To encourage saving, employees who do not make an election are automatically enrolled at a 4% contribution rate, which will increase by 1% each year until reaching 10%, unless changed or opted out. The plan, administered by TIAA, allows participants to choose how their funds are invested and to adjust contribution amounts or investment allocations at any time. On the TIAA website, employees can easily review balances, change investment elections, use retirement planning tools and calculators, and access educational resources to help guide their financial decisions.

All college contributions are subject to a four-year vesting schedule, ensuring that your commitment to Augustana is matched by our commitment to your future. To help employees make informed financial decisions, TIAA representatives provide on-campus education and personalized retirement planning sessions. With Augustana's support, you can take confident steps toward a secure and rewarding retirement.

# OTHER EMPLOYEE BENEFITS

## Time Off Policy

At Augustana College, we believe that time away from work is essential for renewal, balance, and overall well-being. Our Paid Time Off (PTO) program gives employees the flexibility to take time for what matters most—whether that's a well-deserved vacation, attending to personal needs, caring for a loved one, or simply recharging. PTO may be used for both planned absences, such as vacations and medical appointments, and unplanned absences due to illness or family emergencies.

Administrative and staff employees who work 20 hours or more per week are eligible for PTO, becoming eligible on the first of the month after 60 days of employment. PTO is awarded twice per fiscal year—in July and January for 12-month employees, and in September and January for academic-year or 10-month schedules. PTO awards grow with years of service, ranging from approximately 19 to 29 days per year for full-time employees, with prorated awards for part-time staff. To encourage regular rest and balance, PTO follows a "use it or lose it" structure, though employees may carry over up to a maximum 24 hours into the next fiscal year.

Salaried faculty and coaches are not eligible for PTO under this policy but observe academic breaks and may adjust their schedules as needed to accommodate time away. In addition, these employees may be eligible for other forms of paid leave. Employees with questions about eligibility or time-off options should contact Human Resources for guidance.

Requesting and managing PTO is simple through Paycor, where employees can submit time-off requests, view approval status, and check their available balance at any time. We encourage all employees to take time to rest, recharge, and return ready to contribute their best—because when you take care of yourself, you help strengthen the entire Augustana community.

## Holiday Policy

Augustana College observes 12 paid holidays each year, including New Year's Day, Good Friday, Memorial Day, Juneteenth, Independence Day, Labor Day, the Wednesday through Friday of Thanksgiving week, Christmas Eve, Christmas Day, and New Year's Eve. When a holiday falls on a weekend, it is observed on the nearest weekday so employees can fully enjoy the break.

Full-time employees receive pay for eight hours for each holiday, while part-time employees scheduled for 20 or more hours per week receive prorated pay based on their regular schedule. Non-exempt employees who are required to work on a holiday receive premium pay for the hours worked, in addition to their regular holiday pay.

As a special recognition of the hard work and dedication of Augustana's employees, the college also provides an extended Winter Break—the week between Christmas and New Year's Day—when campus offices are closed. These days off are extra holidays, not deducted from PTO, offering employees an additional opportunity to rest, recharge, and celebrate with family and friends before the new year begins. A full holiday schedule and benefit details are available on the Human Resources website.

# REQUIRED NOTICES

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

1. Indexed annually; see 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% 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.

## Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

### Loss of Other Coverage

If you are declining 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 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

### Marriage, Birth or Adoption

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

### Medicaid or CHIP

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

### For More Information or Assistance

To request special enrollment or obtain more information, please contact:
Cristina Rios, 309.794.7740. cristinarios@augustana.edu

# REQUIRED NOTICES

## Your Information. Your Rights. Our Responsibilities.

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

### Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

### Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

# REQUIRED NOTICES

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share**. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

# REQUIRED NOTICES

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

- January 1, 2026
- Cristina Rios, 309.794.7740. cristinarios@augustana.edu

# REQUIRED NOTICES

## Important Notice from Augustana College 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 Augustana College 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Augustana College has determined that the prescription drug coverage offered by the Medical and Pharmacy plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Medical and Pharmacy plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Medical and Pharmacy plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

**When Can You Join A Medicare Drug Plan?**

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

However, if you decide to drop your current coverage with Augustana College, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Medical and Pharmacy plan.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

Since the coverage under the Medical and Pharmacy plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current coverage will be be affected for you and your dependents. See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

- Contact the person listed below for further information contact Cristina Rios, 309.794.7740. cristinarios@augustana.edu

**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 Augustana College changes. You also may request a copy of this notice at any time.

# REQUIRED NOTICES

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

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

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

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

Date: 01/01/2026
Name of Entity/Sender: Augustana College
Contact--Position/Office: Cristina Rios, Human Resources
Address: 639 38th Street, Rock Island, IL 61021
Phone Number: 309.794.7740

**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 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.

# REQUIRED NOTICES

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 after the qualifying event occurs. You must provide this notice to: Cristina Rios, 309.794.7740. cristinarios@augustana.edu**

### 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.

# REQUIRED NOTICES

### 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 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

### If you have questions

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

Cristina Rios, 309.794.7740. cristinarios@augustana.edu
https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

## Women's Health and Cancer Rights Act

### Enrollment Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the 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. Therefore, the following deductibles and coinsurance apply: See pages 9-10 of this guide. If you would like more information on WHCRA benefits, call your plan administrator at 800.826.9781

### Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, 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? Call your plan administrator at 800.826.9781 for more information.

# REQUIRED NOTICES

## Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

## Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

**YOU ARE PROTECTED FROM BALANCE BILLING FOR:**

**Emergency services**
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

**Certain services at an in-network hospital or ambulatory surgical center**
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

# REQUIRED NOTICES

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

**WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**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 on the next page is of states is current as of July 31, 2025. Contact your State for more information on eligibility.

# REQUIRED NOTICES

| STATE | WEBSITE/EMAIL | PHONE |
|---|---|---|
| **Alabama** Medicaid | myalhipp.com | 855-692-5447 |
| **Alaska** Medicaid | Premium Payment Program: myakhipp.com<br>Medicaid Eligibility: health.alaska.gov/dpa<br>Email: customerservice@myakhipp.com | 866-251-4861 |
| **Arkansas** Medicaid | http://myarhipp.com/ | 855-MyARHIPP<br>(855-692-7447) |
| **California** Medicaid | dhcs.ca.gov/hipp<br>Email: hipp@dhcs.ca.gov | 916-445-8322<br>916-440-5676 (fax) |
| **Colorado** Medicaid and CHIP | Medicaid: healthfirstcolorado.com<br>CHIP: hcpf.colorado.gov/child-health-plan-plus<br>HIBI: mycohibi.com | 800-221-3943 Relay 711<br>800-359-1991 Relay 711<br>855-692-6442 |
| **Florida** Medicaid | flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html | 877-357-3268 |
| **Georgia** Medicaid | HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp<br>CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | 678-564-1162, press 1<br>678-564-1162, press 2 |
| **Indiana** Medicaid | HIPP: https://www.in.gov/fssa/dfr/<br>All other Medicaid: in.gov/medicaid | 800-403-0864<br>800-457-4584 |
| **Iowa** Medicaid and CHIP | Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid<br>CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki<br>HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp | 800-338-8366<br>800-257-8563<br>888-346-9562 |
| **Kansas** Medicaid | kancare.ks.gov | 800-792-4884<br>HIPP: 800-967-4660 |
| **Kentucky** Medicaid and CHIP | KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>KI-HIPP Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP: kynect.ky.gov<br>Medicaid: chfs.ky.gov/agencies/dms | KI-HIPP: 855-459-6328<br>KCHIP: 877-524-4718 |
| **Louisiana** Medicaid | ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp | Medicaid: 888-342-6207<br>LaHIPP: 855-618-5488 |
| **Maine** Medicaid | Enrollment: mymaineconnection.gov/benefits<br>Private health insurance premium: maine.gov/dhhs/ofi/applications-forms | Enroll: 800-442-6003<br>Private HIP: 800-977-6740<br>TTY/Relay: 711 |
| **Massachusetts** Medicaid and CHIP | mass.gov/masshealth/pa<br>Email: masspremassistance@accenture.com | 800-862-4840<br>TTY/Relay: 711 |
| **Minnesota** Medicaid | mn.gov/dhs/health-care-coverage | 800-657-3672 |
| **Missouri** Medicaid | dss.mo.gov/mhd/participants/pages/hipp.htm | 573-751-2005 |
| **Montana** Medicaid | HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>HIPP Email: HHSHIPPProgram@mt.gov | 800-694-3084 |
| **Nebraska** Medicaid | ACCESSNebraska.ne.gov | 855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **Nevada** Medicaid | Medicaid: dhcfp.nv.gov | 800-992-0900 |
| **New Hampshire** Medicaid | dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov | 603-271-5218 or<br>800-852-3345, ext. 15218 |

# REQUIRED NOTICES

| | | |
|---|---|---|
| **New Jersey**<br>Medicaid and CHIP | Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid<br>CHIP: njfamilycare.org/index.html | Medicaid: 800-356-1561<br>CHIP Premium Assist: 609-631-2392<br>CHIP: 800-701-0710<br>TTY/Relay: 711 |
| **New York**<br>Medicaid | health.ny.gov/health_care/medicaid | 800-541-2831 |
| **North Carolina**<br>Medicaid | medicaid.ncdhhs.gov | 919-855-4100 |
| **North Dakota**<br>Medicaid | hhs.nd.gov/healthcare | 844-854-4825 |
| **Oklahoma**<br>Medicaid and CHIP | insureoklahoma.org | 888-365-3742 |
| **Oregon**<br>Medicaid | healthcare.oregon.gov/Pages/index.aspx | 800-699-9075 |
| **Pennsylvania**<br>Medicaid and CHIP | Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx | Medicaid: 800-692-7462<br>CHIP: 800-986-KIDS (5437) |
| **Rhode Island**<br>Medicaid and CHIP | eohhs.ri.gov | 855-697-4347 or<br>401-462-0311 (Direct RIte) |
| **South Carolina**<br>Medicaid | scdhhs.gov | 888-549-0820 |
| **South Dakota**<br>Medicaid | dss.sd.gov | 888-828-0059 |
| **Texas**<br>Medicaid | hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program | 800-440-0493 |
| **Utah**<br>Medicaid and CHIP | UPP: medicaid.utah.gov/upp/<br>UPP Email: upp@utah.gov<br>Adult Expansion: medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/<br>CHIP: chip.utah.gov | UPP: 877-222-2542 |
| **Vermont**<br>Medicaid | dvha.vermont.gov/members/medicaid/hipp-program | 800-250-8427 |
| **Virginia**<br>Medicaid and CHIP | coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs | Medicaid/CHIP: 800-432-5924 |
| **Washington**<br>Medicaid | hca.wa.gov | 800-562-3022 |
| **West Virginia**<br>Medicaid and CHIP | dhhr.wv.gov/bms/<br>mywvhipp.com/ | Medicaid: 304-558-1700<br>CHIP: 855-699-8447 |
| **Wisconsin**<br>Medicaid and CHIP | dhs.wisconsin.gov/badgercareplus/p-10095.htm | 800-362-3002 |
| **Wyoming**<br>Medicaid | health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility | 800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

**Patient Protection Notice**

UMR generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UMR at 800.826.9781.

You do not need prior authorization from UMR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UMR at 800.826.9781.


CREATED BY HOLMES MURPHY & ASSOCIATES FOR AUGUSTANA COLLEGE