2022 | Benefits Resource Guide (COBRA)

AUGSBURG UNIVERSITY®

Medical Benefits

Augsburg understands the importance of medical coverage and is committed to providing high-quality health care benefits to you and your eligible dependents. We offer two medical plans with two networks through HealthPartners. Both plans provide high-quality, affordable medical care, hospitalization, and emergency care; however, each plan has unique characteristics and advantages. Details of the plans, as well as a plan comparison, are included to help you make an informed decision about the coverage that best meets your needs and those of your eligible dependents.

Your Plan Options

Regardless of which network you choose, routine preventive care is covered at 100%; no deductible or coinsurance is required. You are responsible for all other medical expenses until you satisfy the annual deductible. The deductible is the amount you must pay out-of-pocket before the plan will pay for a portion of covered services. Both plans have an embedded deductible component. Each family member has their own individual deductible. Once the individual deductible is met, then HealthPartners will share costs with coinsurance for that individual. Once the overall family deductible is met by multiple family members, coinsurance applies for all applicable family members.

REMINDER:
When you enroll, there will be four (4) options to choose from – two plans and two networks.

Low Deductible Plan

For in-network expenses, the deductible is $1,250 per person and $2,500 per family. The low deductible plan also offers a prescription drug co-pay benefit. Once you have met your deductible, HealthPartners begins to share in the cost of services – this is called coinsurance. HealthPartners pays 80% of the cost and you pay 20% until you reach your out-of-pocket maximum. At that point, the plan pays 100% of all eligible expenses for the remainder of the calendar year.

High Deductible + HSA Plan

For in-network expenses, the deductible is $2,800 per person and $5,600 per family. Once you have met your deductible, HealthPartners begins to share in the cost of services – this is called coinsurance. HealthPartners pays 80% of the cost and you pay 20% of the cost until you reach your out-of-pocket maximum. At that point, the plan pays 100% of all eligible expenses for the remainder of the calendar year.

AUGSBURG UNIVERSITY

Medical Benefits

Your Network Options

You will need to choose a network option when you enroll.

Achieve Network

This network, offered through HealthPartners, includes about 72 percent of the Twin Cities and St. Cloud area providers that are in the Open Access network. The Achieve network is metro-centric and is only available to employees who live in the following 14 counties: (Minnesota) Anoka, Benton, Carver, Dakota, Hennepin, Scott, Sherburne, Stearns, Ramsey, Washington and Wright; (Western Wisconsin) Polk, Saint Croix and Pierce. ALL care for you and your family members needs to be received in the Achieve network. Members with the Achieve network have in-network coverage through HealthPartners' national network.

NOTE: If an in-network provider refers you for covered services to another provider (such as a lab or specialist), it is your responsibility to make sure the provider you have been referred to is also an in-network provider.

Open Access Network

This very broad network will continue to be offered in partnership with Cigna. It provides access to more than 700,000 doctors and care providers, and approximately 5,800 hospitals nationwide. In addition, members may see any specialist in the network with no referrals needed.

Finding Network Providers

OPEN ACCESS

- Go to www.healthpartners.com/openaccess

ACHIEVE

- Go to www.healthpartners.com/achieve
- Or call customer service at 800.883.2177

Keep in mind: *If you are using out-of-network providers, the costs above the usual and customary rate are not subject to the out-of-pocket maximum.*

Medical Premiums

Low Deductible Plan

Your Monthly Cost for COBRA		
Network	Open Access	Achieve
Employee Only:	$736.35	$692.17
Employee + Child(ren):	$1,244.46	$1,169.79
Employee + Spouse/Partner:	$1,693.63	$ 1,592.01
Family:	$2,429.99	$2,284.19

High Deductible + HSA Plan

Your Monthly Cost for COBRA		
Network	Open Access	Achieve
Employee Only:	$674.25	$633.80
Employee + Child(ren):	$1,139.50	$1,071.13
Employee + Spouse/Partner:	$1,550.79	$1,457.74
Family:	$2,225.05	$ 2,091.53

These premiums include the 2% COBRA administration fee.

Summary of In-Network Medical Benefits*

	Low Deductible Plan *Open Access or Achieve Network*	High Deductible + HSA Plan *Open Access or Achieve Network*
Calendar Year Deductible	$1,250 Single $2,500 Family	$2,800 Single $5,600 Family
Coinsurance	Plan pays 80%, you pay 20% after deductible	Plan pays 80%, you pay 20% after deductible
Calendar Year Out-of-Pocket Maximum Lifetime Maximum	$5,000 Single $10,000 Family Unlimited	$5,000 Single $10,000 Family Unlimited
Routine Preventive Care • Routine physical, eye exams, immunizations • Prenatal, postnatal & well child	100% coverage	100% coverage
Office Visits / Urgent Care	Plan pays 80%, you pay 20% after deductible	Plan pays 80%, you pay 20% after deductible
Convenience Care • Retail clinics	Plan pays 80%, you pay 20% after deductible	Plan pays 80%, you pay 20% after deductible
Emergency Care • Care at a hospital ER, ambulance	Plan pays 80%, you pay 20% after deductible	Plan pays 80%, you pay 20% after deductible
Inpatient / Outpatient Care • Facility fee, Physician/Surgeon fee	Plan pays 80%, you pay 20% after deductible	Plan pays 80%, you pay 20% after deductible
Prescription Drugs Retail (30 day supply): - Generic Formulary - Generic Non-Formulary - Formulary Brand - Non-Formulary Brand - Specialty Mail Order (90 day supply): - Generic Formulary - Generic Non-Formulary - Formulary Brand - Non-Formulary Brand - Specialty	 $15 copay $100 copay $50 copay $100 copay 80% to $200 max per prescription per month $45 copay $200 copay $150 copay $300 copay N/A	 Generic: Plan pays 100%, you pay 0% after deductible. $12 copay for Select Preventive Drugs Formulary Brand: Plan pays 100%, you pay 0% after deductible. $45 copay for Select Preventive Drugs Non-Formulary Brand: Plan pays 100%, you pay 0% after deductible. Preventive drug benefit does not apply. Specialty: Plan pays 80%, you pay 0% after deductible up to $200 max per prescription per month

** You will receive the highest level of benefit when utilizing an in-network provider. Please refer to applicable plan documents for out-of-network benefits.*

Affordable Care Act (ACA) and Medicare Compliance

These plans provide minimum essential coverage and meet the minimum value standard for the benefits they provide. In addition, both plans have creditable drug coverage.

Employee Assistance Program (EAP)

We are pleased to offer an Employee Assistance Program through HealthPartners. This program is designed to help employees with personal and/or work-related issues that may impact job performance, overall health and mental and emotional well-being.

The Elevate EAP offering provides extended support for those experiencing anxiety or depression.

Services include:

- In-depth assessment and administration of psychometric test
- Up to 20 face-to-face counseling sessions with a psychologist
- Complementary treatment plans
- Ongoing case management

Accessing the HealthPartners EAP is easy:

- Call 866.326.7194 to learn more!
- Go to **hpeap.com**
  - Enter your password: Augsburg

Medical Plan Terms You Should Know

The following terms describe key features of your medical plan options. Be sure to review these terms so that you understand your potential costs under both plans.

Preventive Care

Routine preventive care is covered at 100% from in-network providers. This includes annual wellness exams and certain screenings based on age for you and your covered dependents.

Copay

The fixed-dollar amount you pay for certain prescription drugs. After you pay this amount, the plan pays the rest of the cost of your prescription. Copays do not apply towards your deductible but do apply to your out-of-pocket maximum.

Deductible

The annual amount you must pay for non-preventive services before either plan will pay benefits. You are responsible for the full cost of applicable services until your total costs exceed your deductible. There is a separate deductible when you use out-of-network providers.

Embedded Deductible

With the embedded deductible component (applicable to both plans), each family member has their own individual deductible. Once you meet your individual deductible, then HealthPartners will start to share costs with coinsurance for that individual. Once the family deductible is met by multiple family members, coinsurance applies for all applicable family members.

Coinsurance

The amount you share with the plan to pay for non-preventive care received, up to the annual out-of-pocket maximum. Once you meet your deductible, you and your plan share covered expenses through coinsurance. Coinsurance for out-of-network services is typically higher than for in-network expenses.

Out-of-Pocket Maximum

For your protection, plans have annual out-of-pocket maximums that "cap" the amount you must pay for covered expenses. Once you meet your out-of-pocket maximum, the plan pays your covered expenses for the rest of the calendar year. Deductibles, copays, and coinsurance count toward your out-of-pocket maximum; payroll deductions for cost sharing of premiums do not. Out-of-pocket maximums differ for in-network and out-of-network services.

Usual and Customary (U&C)

Payment for health care services received out-of-network is based on U&C rates. The rate will be used to determine how much will be paid for a specific service. You will be responsible for the difference between what is charged by the provider and what the plan considers U&C plus any applicable coinsurance.

Medical Benefits

Resources

Manage Your Health Online

Once you are enrolled in the HealthPartners medical plan, create a myHealthPartners account at **www.healthpartners.com**. Once registered, you can:

- Look up your benefits information.
- See your claims and explanations of benefits (EOBs).
- Search for doctors in your network.
- Sign up to get your health plan documents delivered online.

Manage Your Health Care Costs

Log on to your **myHealthPartners** account to check your plan balances, including your deductible and out-of-pocket balance.

- Compare costs for doctors, treatments and more with different cost calculators.
- Estimate your yearly health care costs with the annual planning tool.

Manage Your Prescriptions

Find out if your prescriptions are covered by searching the **PreferredRx** formulary.

- Go to **www.healthpartners.com/preferredrx** and search by medicine name, category or first letter.
- Generics will be in all lower-case italics.
- Brand will be in all CAPS.
- Specialty Drug will include a specialty icon.

Review the HSA preventive drug list by going to **https://www.healthpartners.com/hp/pharmacy/druglist/index.html** and clicking "See HSA preventive drug list"

Get Support for Your Health

HealthPartners Healthy Living

Whether you're looking to get healthy or stay healthy, HealthPartners is here to support you.

Visit **www.healthpartners.com/healthyliving** to:

- Get discounts at health and well-being retailers nationwide. Log on to your myHealthPartners account for details.
- Check out the Health Information Library and decision support tools to help you make health care decisions based on what's important to you.
- Work with a virtual coach to get active, quit smoking, stress less and move more.

Wellbeats

You have access to hundreds of on demand virtual fitness classes, fitness assessments and challenges online or through an Android or iOS app. These benefits include:

- 450+ high quality, 1-50 minute videos
- 29 channels, no equipment options, for every age, interest and ability
- Goal based challenges and fitness assessments
- Highly certified, relatable, motivating instructors
- Ability to track and measure progress

To access Wellbeats, first login to the HealthPartners portal at **healthpartners.com**. Then go the Healthy Living tab and select "Health assessment." Find the Wellbeats activity card and click "Get started."

virtuwell.com®

You can visit with a nurse practitioner, receive a diagnosis, and/or get prescribed medication, all from your computer or a simple phone call. The cost is only $59 per consult and can be used to treat over 60 conditions and minor illnesses.

Visit **www.virtuwell.com** for more information or call 952-883-5000 or 800-883-2177.

Doctor On Demand®

You can visit with a board-certified doctor, receive a diagnosis, and/or get prescribed medication, all from your smartphone, tablet, or computer with video access. The cost is only $59. You also have access to behavioral health virtual visits. Prices vary.

Visit **www.doctorondemand.com** to get started.

Dental Benefits

Maintaining your dental health by having regular preventive services may not only prevent major costs in the future but is also good for your overall health. Augsburg offers dental coverage through Delta Dental of Minnesota. You have two provider networks to choose from: Delta Dental PPO and Delta Dental Premier. You will receive the highest level of benefit by using providers in the Delta Dental PPO network, but providers in both networks offer services at negotiated rates.

If you use an out-of-network/non-participating provider, you may be required to submit a claim to receive benefits and you may pay more based on usual and customary fees.

Easy Access to Dental Information

Delta Dental provides you easy access to your dental information when you visit **www.deltadentalmn.org** to:

- Find a network dentist.
- View your benefit plan coverage.
- Estimate the average cost of dental procedures using Fee Finder.
- View claims information.
- Print an ID card.

Finding a Network Provider

- Visit **www.deltadentalmn.org** and select Delta Dental PPO or Delta Dental Premier
- Call Delta Dental of Minnesota **1.800.448.3815**

Your Monthly Cost for COBRA	
Employee Only:	$38.56
Employee + Child(ren):	$102.00
Employee + Spouse/Partner:	$96.90
Family:	$114.24

These premiums include the 2% COBRA administration fee.

	Delta Dental PPO Network	Delta Dental Premier Network	Non-Participating Providers
Diagnostic & Preventive	100%	100%	100%
Basic Restorative Services		80%	80%
Basic Endodontics			
Basic Periodontics			
Basic Oral Surgery			
Major Services	60%	50%	50%
Orthodontics (*adults and children age 8+*)			
Annual Deductible (*applies to all non-preventive services*)	$25 per person $75 per family	$50 per person $150 per family	$50 per person $150 per family
Annual Plan Maximum	$2,000 per person	$1,000 per person	$1,000 per person
Orthodontic Lifetime Maximum	$2,000	$1,000	$1,000

Note: Network providers have agreed to accept Delta's maximum allowable fee as payment in full. Non-participating dentists are not obligated to limit the amount they charge, so their fee may be higher than the maximum allowable charge. If this is the case, your benefits will be based off of the maximum allowable fee and you will be responsible for paying any difference to the provider.

Vision Benefits

Augsburg offers a voluntary vision plan through EyeMed. This vision plan features coverage for prescription eyewear through a network of participating vision care providers. You will receive a greater level of benefit when you use the EyeMed Insight network. In addition, when you use network providers, you may receive discounts and savings for services not otherwise covered by the vision plan, including sunglasses and laser vision correction.

*Please note: This plan provides coverage for materials/hardware **ONLY**. Coverage for the vision exam is provided through your medical insurance.*

Easy Access to Vision Information

EyeMed provides you easy access to your vision information when you visit **www.eyemed.com** to:

- Find a network provider.
- View your benefits.
- View claims information.
- View special offers.

Importance of the Well Vision Exam

Your vision exam doesn't only assess your need for prescription eyewear, it also screens for high blood pressure, diabetes and high cholesterol.

NOTE: HealthPartners members have coverage for eye exams at no cost as part of the preventive coverage offered under both medical plan options.

Finding a Network Provider

- Visit **www.eyemed.com** or call **888.203.7437**
- For Lasik providers, visit **www.eyemedlasik.com** or call **877.5LASER6**

Your Monthly Cost for COBRA	
Employee Only:	$4.41
Employee + Child(ren):	$8.81
Employee + Spouse/Partner:	$8.36
Family:	$12.95

These premiums include the 2% COBRA administration fee.

	EyeMed Insight Network
Spectacle Lenses	
• Standard Single Vision	$25 copay
• Standard Bifocal	$25 copay
• Standard Trifocal	$25 copay
• Standard Progressive	$90 copay
Frames	$130 allowance, 20% off balance over $130
Contact Lenses	
• Conventional	$130 allowance, 15% off balance over $130
• Disposable	$130 allowance
• Medically Necessary	Paid-in-Full
Laser Vision Correction	15% off retail price
Frequency	
• Lenses or Contact lenses	Once every 12 months
• Frames	Once every 24 months

Note: Contact lenses are in lieu of spectacle lenses and frames. However, members may still be able to receive additional discounts off another complete pair of eyeglasses or conventional contact lenses once the covered benefit has been used. Contact lenses and out-of-network benefits are not subject to copayments. Please consult your plan document for specific out-of-network benefits.

Important Notices

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave to address critical personal and family matters. It is the policy of **your employer** and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The "break in service cap" doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and your Human Resources Department and call your FMLA Administrator at least 30 calendar days in advance of the start of the leave when the need for such leave is reasonably foreseeable (as in the case of a birth, the placement for adoption of a son or daughter, or a planned medical treatment for a serious health condition).

However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.
Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);

Number of eligible dependents (for example, birth, death, adoption, placement for adoption);

- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit www.healthcare.gov for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

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 enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Human Resource Department

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 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 a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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)**.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
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: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
P: 866.444.EBSA (3272)

U.S. Department and Human Services Center for Medicare & Medicaid Services
www.cms.hhs.gov
P: 877.267.2323 Menu Option 4, Ext. 61565

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

AUGSBURG UNIVERSITY

MNsure Coverage Options and Your Health Coverage: For Employees Whose Employers offer health coverage

General Information

When key parts of the health care law known as the Affordable Care Act take effect, there will be a new place to buy health insurance in Minnesota; MNsure. To assist you as you evaluate options for you and your family, this notice provides some basic information about MNsure and employment-based health coverage offered by your employer.

What is MNsure?

MNsure is designed to help you find health insurance that meets your needs and fits your budget. MNsure offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium for health insurance plans sold through MNsure or free or low-cost insurance from Medical Assistance or MinnesotaCare. Open enrollment for health insurance coverage through MNsure begins November 1, 2021 for coverage starting as early as January 1, 2022.

Can I Save Money on my Health Insurance Premiums through MNsure?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through MNsure?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit or MinnesotaCare through MNsure and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, a reduction in certain cost- sharing, or MinnesotaCare if your employer does not offer coverage that meets certain standards. If the cost of a plan from your employer for you, the employee only, is more than 9.863% for 2021 and 9.61% for 2022 of your household income for the year, or if the coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

If you are seeking help paying costs for health coverage through MNsure, you will need information about the cost and value of your employer coverage to complete an online or paper application. If your employer offers health coverage to you, ask your employer to complete and give you the Health Coverage from Jobs (Appendix A) form. If your employer does not offer coverage to you, you do not need your employer to complete the Health Coverage from Jobs (Appendix A) form.

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

How Can I Get More Information?

There is help available to you to evaluate your coverage options through MNsure, including your eligibility for coverage through MNsure and its cost. Please visit **www.mnsure.org** for more information, including an online application for health insurance coverage, or call 1-855-3MNsure (1-855-366-7873).

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

Important Resources

These resources are available to answer your questions and provide information about your benefits.

Benefit	Carrier / Administrator	Contact Information	Information Available
Medical Plans Group Number: 3396	HealthPartners • Member Services • Main Website • 24-Hour Care Advice Line • Stop Smoking Program	952.883.5000 or 800.883.2177 *Additional resources located on the back of your ID card* www.healthpartners.com 800.551.0859 800.551.0859	• Look up benefit information • See your claims and explanation of benefits (EOBs) • Search doctors in your network • Sign up to get your health plan documents delivered online
Dental Group Number: 50627	Delta Dental of MN	1.800.448.3815 www.deltadentalmn.org	• Find a network dentist • View your benefit coverage • Estimate the average price per procedure • View claims information • Print an ID card
Vision Group Number: 1008622	EyeMed	888.203.7437 www.eyemed.com	• Find a network provider • View your benefits • View claims information • Print an ID card
Employee Assistance Program (EAP)	HealthPartners EAP	866.326.7194 hpeap.com	• EAP Counseling • Work/Life Balance • Depression & Anxiety Assistance