2026 | Benefits Resource Guide

AUGSBURG UNIVERSITY.

Welcome to Augsburg!

Whether you are a new or a long-standing Auggie, we are pleased to have you as a part of the Augsburg community. Attracting and retaining talented, dedicated faculty and staff is important to the success of Augsburg University. We know that our team member's attitudes toward their benefits are correlated with their levels of commitment and engagement with the University. Augsburg strives to provide meaningful benefits that are affordable and meet the needs of our faculty and staff, and their families.

Using this Interactive Guide

You can navigate by clicking on any of the sections listed below, then direct yourself back to this page just by clicking the "home" icon in the upper right corner of each page. Most URL's are hyperlinked so you can easily go to the web address that is referenced.

What's Inside

Plan Information

As a benefits-eligible Augsburg faculty or staff member, you have a variety of benefit options to choose from. This benefit guide provides an overview of the plans available to you, how each benefit works, and who administers the plans. Please review this guide, share it with your family and keep it for future reference.

Who's Eligible

If you are a regular faculty or staff member working 0.75 FTE or greater, you are eligible to participate in Augsburg's benefit program on the first day of the month following, or coinciding with, your date of hire.

You can also enroll your eligible dependents. Eligible dependents include:

- Your spouse
- Your domestic partner
- Your children under age 26
  - Dependent age limits vary by plan. Please see plan documents for further information.

Eligible children include your children, step-children, foster children, children you adopt or who are placed in your home pending adoption, children for whom you are required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO), and unmarried children of any age who have a mental or physical disability and are incapable of self-support and are financially dependent on you.

Changing Your Elections

The benefit choices you make will remain in effect for the entire calendar year. You are, however, allowed to modify your elections in certain situations, called "qualifying life events." If you experience a qualifying life event, as described below, you may make changes to your benefits within 30 days of the event.

Your benefit changes must be consistent with the life event you experienced. The new election becomes effective as of the date of the change in status or loss of coverage, whichever comes later.

Qualifying Life Event

You may make changes to your benefits if you experience any of the following events:

- *Marriage*
- *Birth or adoption of a child*
- *Legal separation, divorce or annulment of marriage*
- *Death of a spouse or dependent*
- *Dependent loses eligibility due to marriage or reaching maximum age of 26*
- *Your spouse or dependent starts or leaves a job*
- *A switch in employment status from full-time to part-time or from part-time to full-time by you, your spouse or your dependent*

Cost of Coverage or Tax Implications

Who Pays	Benefits	Pre- or Post-Tax Basis
Augsburg	• Basic Term/AD&D • Long-Term Disability • Kavira	• You pay tax on Basic Life benefit value over $50,000
Augsburg & Employee	• Medical • MN PFML	• Pre-tax • Post-tax
Employee	• Dental • Health Savings Account • Vision • Health Care & Limited Purpose FSAs • Dependent Care FSA • Voluntary Life/AD&D • Pet Insurance	• Pre-tax • Pre-tax • Pre-tax • Pre-tax • Pre-tax • Post-tax • Post-tax

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. Augsburg's medical benefit is insured by Medica. You are offered two (2) medical plans with three (3) networks to choose from. 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.

Visit **welcometomedica.com/augsburguniversity** for additional information with side-by-side comparisons of the plans. Find a doctor, or review what each plan offers along with some of the value-added benefits.

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 Medica 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 six (6) options to choose from – two plans and three networks.

Low Deductible Plan

For in-network expenses, the deductible is $1,500 per person and $3,000 per family. The low deductible plan also offers a prescription drug co-pay benefit. Once you have met your deductible, Medica begins to share in the cost of services – this is called coinsurance. Medica 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.

To help pay for qualified medical expenses, participants of this plan are eligible to contribute to a Flexible Spending Account with pre-tax deductions through payroll. Refer to the **Flexible Spending Account** section to learn more.

High Deductible + HSA Plan

For in-network expenses, the deductible is $3,400 per person and $6,800 per family. Once you have met your deductible, Medica begins to share in the cost of services – this is called coinsurance. Medica 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.

To help pay for qualified medical expenses, high deductible health plan participants are eligible to contribute to a Health Savings Account with pre-tax deductions through payroll. Refer to the **Health Savings Account** section to learn more.

Medical Benefits

Your Network Options

It is in your best interest to seek providers who are in-network. If you see a provider that is not in your Medica network, your costs will be significantly higher because you receive a lower coverage amount under your benefit plan – and your share of the costs is based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. Also, the costs above the usual and customary (U&C) rate are not subject to the out-of-pocket maximum. So once the total of your out-of-network U&C charges reach your out-of-pocket maximum, the plan will pay 100% of the remaining U&C charges, but you continue to pay the full cost of any charges above U&C.

The following is a brief description of the **networks** available to you:

- **Choice Passport** – Medica's largest, national network has access to more than 1 million providers and nearly 7,300 hospitals across the U.S. For care received within the Medica service area, you have the Medica Choice Passport open access network. For care received outside of the Medica service area (students, while traveling, etc.) you have access to the UnitedHealthcare national network. You are free to see any provider in the Medica network (without a referral) and you are not required to select a primary care clinic.
- **Park Nicollet & HealthPartners Medical Group First ACO** – A separate, smaller network of providers delivering services at lower rates. You save money on your monthly premium, as well as the services you receive. In addition, as an Accountable Care Organization (ACO) this network delivers the same services, innovation and technology of leading national networks right here, locally. This network includes direct access to more than 55 medical and surgical specialties, 50 neighborhood clinics, 18 specialty care centers, 20 urgent care locations, and 6 hospitals. You are free to see any in-network provider –and no referral is necessary.
- **VantagePlus ACO** – A combination of several major care systems and independent providers offering a broad geographic access and a greater focus on lowering health care costs and improvements in service. It provides direct access to more than 4,800 providers, 650 clinics, and 11 hospitals.

KEEP IN MIND – If you are traveling or have family members who live away from home – a child at school, for example – emergency services will always be considered in-network. For children away at school, coverage for routine services like physical therapy or office visits for the flu or an ear infection will depend on where they are located in relation to the Medica service area (Minnesota, North Dakota, South Dakota and western Wisconsin), as follows:

Inside the service area: Routine services will be considered out-of-network unless they are received from a provider in their Park Nicollet & HealthPartners Medical Group First or VantagePlus care system.

Outside the service area: Routine services will be considered in-network as long as they are delivered by a UnitedHealthcare provider. Keep in mind, however, that chiropractic services are not included outside the Medica service area. Your out-of-network benefits would apply in this case.

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.*

Park Nicollet & HealthPartners Medical Group First Network	VantagePlus Network
Park Nicollet HealthPartners Childrens Hospitals & Clinics Regions Hospital St Francis Regional Medical Center	M Health Fairview* North Memorial Childrens Hospitals & Clinics * HealthEast has now integrated with Fairview Health Services

Summary of In-Network Medical Benefits*

	Low Deductible Plan *Passport, Park Nicollet & HP First, or VantagePlus*	High Deductible + HSA Plan *Passport, Park Nicollet & HP First, or VantagePlus*
Calendar Year Deductible	$1,500 Single $3,000 Family	$3,400 Single $6,800 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	$5,500 Single $11,000 Family Unlimited	$6,600 Single $13,200 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 (31 day supply): - Generic - Preferred Brand - Non-Preferred Brand - Specialty Mail Order (91 day supply): - Generic - Preferred Brand - Non-Preferred Brand - Specialty	 $15 copay $50 copay $100 copay Preferred: 80% to $200 max per prescription per month Non-Preferred: 70% after deductible $30 copay $100 copay $200 copay N/A	Generic: Plan pays 100%, you pay 0% after deductible. No charge for designated preventive drugs. Preferred Brand: Plan pays 100%, you pay 0% after deductible. No charge for designated preventive drugs. Non-Preferred Brand: Plan pays 100%, you pay 0% after deductible. Preventive drug benefit does not apply. Preferred Specialty: Plan pays 80%, you pay 0% after deductible up to $200 max per prescription per month Non-Preferred Specialty: 30% after deductible

** 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.

Prescription Drug Coverage

Medica partners with **Express Scripts, Inc. (ESI)**, as the pharmacy benefit manager (PBM) for health plans across all of Medica's segments. High-cost specialty drug management is provided (through Accredo) or medical pharmacy management (through Magellan). Covered drugs are listed on the Medica Preferred Drug List, which is comprised of drugs that provide the most value and have proven safety and effectiveness.

How you pay for your prescriptions will vary by your plan choice and where you fill your prescription.

- **Retail Pharmacy** – Participants in the High Deductible + HSA plan are responsible for the full cost until the deductible has been met. Once the deductible is met, then the plan pays 100% for the remainder of the calendar year. Participants in the Low Deductible plan pay a copay based on the type of drug purchased.

- **Mail Order Pharmacy** – Express Scripts, Inc. is Medica's prescription mail order provider. Mail order provides the convenience of receiving a 3-month supply mailed directly to your home. Low Deductible participants also get a 3-month supply for the cost of two (2) copays. Before deciding if mail order is right for you, compare prices using the Medica Price a Medication tool available on **www.Medica.com/SignIn**. Members will be able to easily start, manage and refill eligible mail order prescriptions using the Express Scripts website (accessible through Medica.com/SignIn) or the Express Scripts mobile app. You can also contact Express Scripts Pharmacy 24/7 by phone at 1.800.263.2398.

Tools and resources are available on **www.Medica.com/SignIn**, as well as a mobile app, that makes it easy for you to check drug costs, locate pharmacies and view your prescription history.

- **93-Day Refill Option** – You can get up to a 93-day supply of ongoing medications from a participating pharmacy with the 93-day refill option. You'll pay three retail copayments or coinsurance amounts (depending on your plan) and get the convenience of saving trips to the pharmacy. To use this option, ask your provider for a 93-day prescription and bring it to a participating pharmacy.

- **Specialty Drugs** – These medicines treat health care conditions like cancer, hepatitis, multiple sclerosis and rheumatoid arthritis. Medications considered "specialty" drugs must be filled through an approved specialty pharmacy or there will be no coverage.

- **Accredo** – Medica partners with Accredo to provide specialty pharmacy services. The Accredo clinical team offers one-on-one counseling and assistance as well as opportunities to engage through web, mobile, text, chat and email to make refilling medications as easy as possible. Specialty medications are conveniently delivered to members via FedEx or UPS. You can contact Accredo by phone at 1.877.ACCREDO (222.7336) or access their website: www.accredo.com

Medical Premiums

Your cost per pay period (pre-tax bi-weekly payroll deduction over 24 pay periods).

Low Deductible Plan

	Employee Cost		University Cost	
Network	Passport	Park Nicollet & HP First OR VantagePlus	Passport	Park Nicollet & HP First OR VantagePlus
Employee Only:	$107.48	$99.32	$379.65	$314.74
Employee + Child(ren):	$276.40	$261.80	$546.86	$437.97
Employee + Spouse/Partner:	$365.40	$347.20	$755.00	$605.14
Family:	$539.81	$511.18	$1,067.73	$855.22

High Deductible + HSA Plan

Employee Cost		University Cost	
Passport	Park Nicollet & HP First OR VantagePlus	Passport	Park Nicollet & HP First OR VantagePlus
$62.40	$58.70	$365.62	$305.12
$210.97	$197.22	$512.41	$417.65
$277.54	$261.54	$706.93	$575.26
$398.22	$373.48	$1,014.28	$827.15

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 Medica 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.

Medica Wellness Discounts and Resources

Medica has a wealth of discounts and resources available for members:

Behavioral Health Support
Connect with on-demand help for stress, depression and anxiety through the **Sanvello app**. Access coping tools, daily mood tracking, guided journeys and weekly progress check-ins to stay engaged and manage symptoms. You receive premium access as part of your plan's behavioral health benefits. Download the Sanvello app from the App Store or Google Play and select ***Upgrade Through Your Insurance*** to get started.

Omada
Empowers you to build healthy behaviors that last. Omada is a digital lifestyle change program for people at risk for chronic conditions like prediabetes, hypertension, high cholesterol and cardiovascular disease. Participants learn how to make meaningful changes and sustain behaviors. Visit **omadahealth.com/Medica** for additional information.

Value for Your Health Care Dollar
Cost and quality can vary significantly among providers. Knowing the difference can help you save money and have better results. Look up cost ranges for common procedures at dozens of facilities using **Main Street Medica**. Or use the online provider search tool to find doctor-specific cost and quality information with Premium Designation. Both tools are available on **Medica.com/SignIn**.

My Health Rewards Program
Taking steps to improve your health might be easier than you think. Whether you want to stress less, quit smoking or eat more fruits and veggies, **My Health Rewards by Medica**® makes it fun — and rewarding. You'll earn rewards as you complete activities personalized just for you. To get started with My Health Rewards, download the Virgin Pulse app, free in the App Store and on Google Play.

24-Hour Health Support
Worried that your stomach bug could be serious? Wondering what to do about that cough that won't go away? The advisors and nurses at **Medica CallLink**® can help. They're available 24 hours a day, 365 days a year to answer your questions and help you make smart decisions about your health. Just call 1.800.962.9497 (TTY users, call 711).

Virtual Care Options

You can access virtual care through providers in your plan's network. Check your virtual care options at **medica.com/findadoctor**. Your virtual care options may include:

Amwell

24/7 online clinic available in every state.

Services

- Treatment of common medical conditions. Visits are typically a lower cost option in comparison to an in-person visit, depending on your plan's coverage for virtual care.
- Behavioral health care services including therapy and psychiatry. Cost per visit may vary depending on your plan and type of service. Eligible services are covered under your plan as a behavioral health office visit.*
- Amwell also offers other online services, but is not an in-network provider for those services. You can use those services, but you will pay the full cost.

How it works

You have a video visit with a board-certified doctor or nurse practitioner using the web or mobile app.

1. To get started, create an account with Amwell. **Smartphone/tablet**: Download the free Amwell app from the Apple Store or on Google Play. **Computer:** Go to **amwell.com/cm. Phone:** Call **1.844.733.3627**.
2. Enter your email address, create a password, then add the requested insurance information from your Medica ID card.
3. Select a doctor or nurse practitioner and follow the prompts to start your visit.
4. The doctor will review your history, answer questions, diagnose, treat and prescribe medication (if needed).
5. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

Virtuwell

24/7 online clinic available in select states.**

Services

- Treatment of common medical conditions. Check the virtuwell website for current pricing. Visits are typically a lower cost option in comparison to an in-person visit depending on your plan's coverage for virtual care.

How it works

You have an online visit with a certified nurse practitioner.

1. Go to **virtuwell.com** and take a quick online interview that checks your medical history and makes sure your problem can be treated online.
2. If you can be treated online, you'll create an account with your contact, insurance, pharmacy, and payment information.
3. A nurse practitioner will review your case and write a personalized treatment plan. You'll get an email or text when your plan is ready.
4. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

Common Conditions for Virtual Care

- Allergies
- Sinus infection
- Bladder infection
- Bronchitis and flu
- Cold and cough
- Ear pain
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Other non-urgent conditions

* To check your plan's coverage for behavioral health, sign in to your member account at **Medica.com/SignIn** or call the number on the back of your Medica ID card..

** Visit **virtuwell.com** for a list of available states.

Kavira

If you want the convenience of receiving everyday healthcare through low to no cost telehealth and home visits, Kavira is right for you!

The goal of this offering is to save you time and money when addressing preventive needs and common acute illnesses within the comfort of your own home (virtually or in-person).

Kavira is available for all Augsburg University medical plan members. Regardless of what medical plan tier you are enrolled in, you and your immediate family will be covered under the Kavira plan.

You start with a virtual visit via text message, video on the Kavira mobile app, or via on-line on your computer. Your care may be able to be completed virtually. Or, if you prefer, you can request an in-home visit.

Kavira is offered at **NO CHARGE** to you with free visits for those on the Low Deductible plan and a copay of only $5 for those on the High Deductible plan (needed in order to remain compliant with IRS-related HSA regulations, and only applicable for non-preventive in-person visits).

Please visit **www.kavirahealth.com** to create your member profile or call **763.373.3856**.

Health care, like it should be.

Virtual Care First

- ✓ Diagnose
- ✓ Prescribe
- ✓ Treatment
- ✓ Peace of Mind

House Visits

When in-person care is needed, our clinicians come to you.

- ✓ In-Home Labs
- ✓ In-Home Exams
- ✓ In-Home X-Rays
- ✓ In-Home Acute Care

KaviraHealth.com

Clinic Hours

House Visits: Weekdays 8am-7pm
Virtual Visits: Weekdays 8am-7pm, Weekends 10am-2pm

Rx Refills & Delivery

Prescription management, Free Rxs, and delivery.

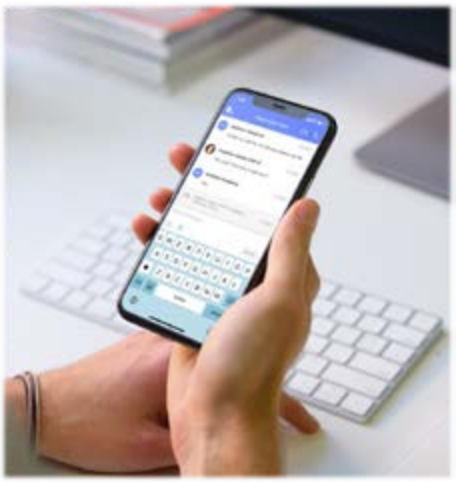
Mobile App

Secure, HIPAA-compliant messaging and video chats with expert providers.

Free Care

Employees and their families receive unlimited free care on demand.*

*First dollar coverage regulations apply for HSA-eligible individuals.



Kavira Benefit Highlights:

- ***100% Free for Employees** – All care for you and your family has already been paid for by your employer
- **Unlimited on-demand** – Our responsive providers are here for you, and there is no limit to the number of visits you or your family may have
- **Complete Convenience** – Prescriptions delivered to your home
- **No paperwork** – Forget filling out and mailing forms – it's all done through the app

* Members who are HSA-eligible will be required to pay a $5 visit fee for non-preventive visits, to stay compliant with HSA regulations

Health Savings Account

A Health Savings Account (HSA) gives you the opportunity to set aside pre-tax dollars to pay for qualified medical expenses. The funds in your HSA roll over from year to year and are yours until you spend them. If you don't use it, you don't lose it.

Plan Eligibility

If you enroll in the High Deductible + HSA Plan, you are eligible to participate in a Health Savings Account (HSA) administered by Chard Snyder.

In order to participate in an HSA:

- You may not be claimed as a dependent on someone else's tax return.
- You may not be covered by another health plan that provides first dollar coverage.
- You and your spouse may not enroll in a medical Flexible Spending Account that could reimburse your medical expenses.
- You may not be enrolled in a government health plan, such as Medicare, Medicaid or TriCare.

HSA Contributions

You may choose to make pre-tax contributions to your HSA through payroll deductions. The amount you are allowed to contribute is governed by federal law and outlined in the chart below. If you are age 55 or older, you may make additional pre-tax catch-up contributions of up to $1,000 a year.

2026 HSA Contribution Limits	
Employee Only:	$4,400
Employee + Child(ren)	$8,750
Employee + Spouse/Partner:	$8,750
Family:	$8,750
Age 55+:	$1,000 catch up contribution

Did you know?

- *The Health Savings Account (HSA) stays with you, even if you change jobs or switch health plans. If you switch to a lower deductible health plan that is ineligible for an HSA, you may continue to use the account for qualified medical expenses, but no longer make deposits.*
- *Faculty and staff over age 65 and enrolled in Medicare may withdraw money from an HSA without penalty, but may not continue to contribute.*

Using Your HSA

You can start, stop or change the amount of your HSA contributions anytime during the year. The HSA enables you to set aside pre-tax dollars to:

- Pay for qualified medical expenses.
- Pay for qualified dental and vision expenses.
- Cover the cost of ongoing out-of-pocket expenses.
- Build savings to cover future medical expenses.

You may use your HSA debit card to pay for qualified health care expenses. You must have a sufficient balance in your HSA to cover the expense. If you pay for any out-of-pocket health care expenses, you may reimburse yourself with the pre-tax dollars from your HSA at a later date.

You own the amount in your account and may take it with you if you change your employment status.

Managing Your HSA

To view your current balance or account activity, you may access your account at **www.chard-snyder.com** or call **800.982.7715**.

Keep your receipts...
If you are audited, you'll need proof that your withdrawals were for qualified eligible expenses.

Flexible Spending Account – Health Care

The Health Care Flexible Spending Account (FSA) gives you the opportunity to set aside pre-tax dollars to pay for qualified medical, dental and vision expenses. Plan your contributions carefully, as funds do not roll over from year to year. If you don't use it, you lose it.

FSA Contributions

You may make pre-tax contributions to your FSA through payroll deductions. The amount you are allowed to contribute is governed by federal law and outlined in the chart below. Keep in mind that you cannot change your election unless you have a corresponding qualifying life event.

Using Your FSA

Your Health Care FSA is used to pay for eligible medical, dental, vision and other health care expenses that you incur. You may pay for eligible health care expenses in one of two ways: using a debit card, or filing a manual claim. Your debit card can be used to pay for copays and to purchase services and supplies from certified merchants. If you are also enrolled in the Dependent Care FSA, this card may be used to pay for eligible dependent care expenses. If you wish to file a claim for reimbursement, the FSA claim form is available by visiting the website or calling customer service. You will need to provide proof of your expense to Chard Snyder.

Visit **www.chard-snyder.com** to:
- File a claim
- Access administrative forms
- Access the Support Center at **www.chard-snyder.com.support-center/**

For assistance by phone, call customer service at: **800.982.7715**

Limited Purpose FSA

Faculty and staff who enroll in the High Deductible + HSA plan and contribute to an HSA may have a Limited Purpose FSA which can **ONLY** be used for qualifying dental and vision expenses.

Keep in mind...
You don't have to participate in an Augsburg medical plan to enroll in the FSA.

Health Care or Limited Purpose FSA	
2026 Annual Contribution Limit	Up to $3,400
Eligible Expenses - Health Care FSA	• Out-of-pocket medical, dental and vision costs, such as deductibles and coinsurance • Prescription drug copayments • Over-the-counter medicine (prescribed by a physician) • Non-covered medical, dental, vision and hearing care expenses
Claims Period	Expenses must be incurred from January 1, through December 31, 2026
Claims Deadline	Claims must be submitted by March 31, 2027
FSA Carryover	Any unused dollars up to $680 in your Medical or Limited Purpose FSAs can be carried over to the following plan year. *(The next rollover will occur after the runout period ends on March 31, 2027.)*
Eligible Expenses - Limited Purpose FSA	Qualifying dental, vision and hearing expenses

Flexible Spending Account – Dependent Care

The dependent care FSA allows you to set aside funds on a pre-tax basis to pay for qualified dependent care expenses.

Dependent Care FSA

If you require dependent care to enable you and/or your spouse to work, look for work or attend school full-time, you may make pre-tax, payroll-deducted contributions to the dependent care FSA to pay for eligible dependent care expenses.

Paying Eligible Expenses

Claims can be paid using your debit card or can be submitted using a claim form found at **www.chard-snyder.com**. Claims are reimbursed only up to the amount available in the FSA when a claim is filed. As part of your reimbursement, you must provide your provider's Social Security # or Tax ID on the claim form.

Dependent Care FSA	
2026 Annual Contributions	Up to $7,500 ($3,750 if you are married and filing separate tax returns)
Eligibility	• Dependent children up to age 13 • Any dependent who is physically or mentally unable to care for themself, who spends at least 8 hours a day in your home, and whom you claim as a dependent on your federal income tax returns
Eligible Expenses	• Preschool or nursery school expenses • Expenses for a babysitter in your home • Day care center • Summer day camp • After-school care • Adult day care center or in-home care for an adult dependent
Claims Period	Expenses must be incurred from January 1, through December 31, 2026
Claims Deadline	Claims must be submitted by March 31, 2027

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 is continuing to offer 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 Cost Per Pay Period **(pre-tax bi-weekly payroll deductions over 24 pay periods)**	
Employee Only:	$20.05
Employee + Child(ren):	$53.05
Employee + Spouse/Partner:	$50.39
Family:	$59.41

	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 continues to offer 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.
- Print an ID card.
- 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: Medica 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 Cost Per Pay Period (pre-tax bi-weekly payroll deductions over 24 pay periods)	
Employee Only:	$2.16
Employee + Child(ren):	$4.32
Employee + Spouse/Partner:	$4.10
Family:	$6.35

	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.

Life and Disability Protection

Protecting your income and your family in the face of death or disability is important. Augsburg provides eligible faculty and staff with Basic Term Life, Accidental Death and Dismemberment (AD&D) and Long-Term Disability coverage at no cost to you. These benefits are offered to you through Unum.

Basic Term Life/AD&D Insurance

The life benefit is payable to your designated beneficiary in the event of your death. AD&D benefits are payable to you in the event of a variety of dismemberments, or an additional benefit is payable to your beneficiary if your death is the result of an accident. The amount of Basic Life insurance available for you is 1.5 times your base annual salary up to a maximum of $200,000.

Your Cost

Augsburg pays the premiums for both life and long-term disability benefits. You only pay a small amount of tax on life insurance amounts over $50,000. This is referred to as imputed income.

Long-Term Disability

Waiting Period	Benefits begin on the 181st day of a qualifying illness or injury.
Duration	Benefits are payable for the length of your qualifying disability until age 65 dependent on your age at time of disability.
Income Replacement	Your maximum benefit is 60% of your monthly basic earnings at the time of disability to a maximum of $5,000 per month. Please see the plan booklet for further details.
Disability Definition	You may be considered disabled if, because of injury or illness, you are unable to perform the material duties of your regular occupation or solely due to injury or illness are unable to earn 80% of your indexed covered earnings.
Taxability	Your monthly benefit is not subject to payroll tax withholding.
Pre-existing Limitations	Pre-existing limitation applies upon enrollment in the plan. Please see the plan booklet for further details.

Additional Life Insurance

You may also choose to buy additional life insurance beyond what Augsburg provides. You may buy coverage for you, your spouse and/or your child(ren) through the voluntary term life option through Unum. This is a group discounted benefit that you pay for through convenient payroll deductions. You are required to purchase additional insurance for yourself in order to purchase coverage for your spouse and/or child(ren). The premium for employee coverage is based on your age. The premium you pay for spousal coverage (if elected) is based on your spouse's age.

	Employee	Spouse	Child
Guarantee Issue Amount	$200,000	$25,000	$10,000
Maximum Benefit	Lesser of 5x annual earnings or $500,000	$250,000, may not exceed 50% of employee amount	$10,000 (Birth to 6 months: $1,000)
Increments	$10,000	$5,000	$1,000
AD&D	$500,000	$250,000	$10,000 (Birth to 6 months: $1,000)

Your Monthly Cost

Age	Employee Coverage Cost per $1,000	
	Non-Smoker	Smoker
< 20	$0.059	$0.100
20-24	$0.059	$0.100
25-29	$0.061	$0.100
30-34	$0.081	$0.127
35-39	$0.100	$0.191
40-44	$0.140	$0.320
45-49	$0.242	$0.549
50-54	$0.440	$0.980
55-59	$0.750	$1.301
60-64	$1.080	$1.691
65-69	$1.790	$3.533
70-74	$2.770	$4.587
75+	$7.400	$9.939

Age	Spouse/Partner Coverage Cost per $1,000
< 20	$0.056
20-24	$0.056
25-29	$0.056
30-34	$0.068
35-39	$0.105
40-44	$0.179
45-49	$0.297
50-54	$0.476
55-59	$0.661
60-64	$0.940
65-69	$1.404
70-74	$2.339
75+	$5.712

Child Rate per $1,000
$0.098

AD&D Rates	
Employee:	$0.036
Spouse:	$0.018
Child:	$0.082

Buy-in, Buy-up

If you enroll at any coverage amount during initial eligibility, you can purchase up to the Guarantee Issue Amount during future annual enrollments.

When is Evidence of Insurability (EOI) Required?

You will need to complete an Evidence of Insurability form if:

- *You are a new or existing faculty or staff member and you elect an amount above the guarantee issue amount.*
- *You didn't elect coverage when you were first eligible.*

Unum will approve or decline applications based on medical underwriting.

Rate Example

You are 40 years old and a non-smoker. You elect $180,000 of Voluntary Life coverage for yourself, $20,000 for your spouse (who is 38 years old), and $10,000 for your child. The monthly premium you would pay would be: $28.28

Employee	*$0.14 x 180 = $25.20*
Spouse	*$0.105 x 20 = $2.10*
Child	*$0.098 x 10 = $0.98*
TOTAL	*$28.28*

Pet Insurance

Augsburg continues to offer pet insurance through Nationwide for all of our animal enthusiasts! This comprehensive plan provides nose-to-tail coverage for your cats and dogs for a wide range of accidents, injuries and illnesses.

Coverage is also available for Avian and Exotic pets.

Visit **www.petinsurance.com/augsburg** or call **877.738.7874** and mention you are with Augsburg University.

Benefits and Your Cost

This is a voluntary benefit – you pay 100% of the cost. Costs vary by plan, coverage options, state of residence and by type of pet.

Nationwide's My Pet Protection gives your pet unbeatable coverage at an unbeatable price.

My Pet Protection
• Accidents and injuries including cuts, sprains, broken bones and allergic reactions
• Common illnesses including ear infections, vomiting and diarrhea
• Serious/Chronic illnesses, including cancer and diabetes
• Hereditary and congenital conditions
• Surgeries and hospitalization
• Visits to any vet, prescription medications and therapeutic diets

Avian and Exotic Plans

Exotic pet insurance plans cover accidents and illnesses as well as examinations, lab fees, prescriptions, X-rays, hospitalization and more. Nationwide covers most birds and a wide range of exotic pets, including:

- Amphibians
- Chameleons
- Chinchillas
- Ferrets
- Geckos
- Gerbils
- Goats
- Guinea pigs
- Hamsters
- Hedgehogs
- Iguanas
- Lizards
- Mice
- Opossums
- Potbellied pigs
- Rats
- Rabbits
- Snakes
- Sugar gliders
- Tortoises
- Turtles

Additional Benefits

403(b) Retirement Plan

Active faculty and staff may begin participating in the TIAA retirement plan at any time after attaining the age of 21. The plan has immediate vesting. Participation in the matching level of the retirement plan may begin after one year of service; you contribute 5% of your base salary on a pre-tax basis and the University matches with a 5% contribution. After four years of matching participation, the University contributes 8%, and no mandatory employee contribution is required. You may, however, continue voluntary contributions.

Tuition Benefit

Benefit-eligible employees, spouses, and dependents may be eligible for tuition benefits at Augsburg University, former ACTC Institutions, ELCA Institutions, and other educational institutions according to each program's requirements. There is a one-year waiting period for benefits. Benefits vary depending on a variety of factors, including but not limited to: the relationship of the student to the employee, the educational program, and the exchange program. Refer to the Augsburg Tuition Benefit Policy for further details.

Student Loan Repayment Tools

Employees of not-for-profit institutions like Augsburg are eligible for federal loan debt relief and repayment programs through the federal government's Public Service Loan Forgiveness (PSLF) programs. However, the enrollment process can be complicated. Savi is offered to Augsburg employees and their immediate family members as a tool to explore the various PSLF options and navigate enrollment. Learn more about **Savi Student Loan Tools.**

Paid Holidays (*eligible staff benefit*)

There are 14 paid holidays per year.

Paid Vacation *(eligible staff benefit)*

Non-exempt Hourly Employees: Accrue 15 days during the first and second year of employment, 18 days during the third and fourth year of employment, and 22 days in the fifth year of employment and beyond.

Exempt Employees: Accrue 22 days per year.

Employees working .5 FTE or greater are eligible to earn pro-rated vacation accruals based on their full-time equivalent percentage.

Please note: Accrual begins on the first full pay period following the date of hire.

Sick Leave

Eligible staff employees accrue four hours per pay period, beginning on the first full pay period following the date of hire. Employees working less than 1.0 FTE may earn pro-rated leave accruals based on their full-time equivalent percentage.

Non-benefits eligible staff and all faculty are eligible for Minneapolis and St. Paul sick leave accruals as required by law.

Short Term Disability *(eligible employee benefit)*

Short-Term Disability (STD) benefits begin after Paid Family and Medical Leave (PFML) benefits end. Short Term Disability (STD) benefits are designed to provide salary continuation during a leave of absence due to non-work-related illness or injury. The benefit amount will be 66% of your weekly salary for the length of disability, for up to an additional 14 weeks after PFML benefits have expired. Documentation stating the necessity for a leave from a health care provider must be provided and approved.

Personal Time *(eligible staff benefit)*

Eligible staff employees are able to use a maximum of five (5) sick days per calendar year to be designated as personal time, on a basis proportionate to the employee's FTE. Personal time is available to conduct personal business not covered under other paid time-off policies. Personal time is deducted concurrently from the balances of both Personal Time and Sick Leave. Sufficient balance to cover Personal Time in the Sick Leave balance is necessary before Personal Time may be used.

Civic Engagement and Community Service Leave *(eligible staff benefit)*

Eligible staff employees are provided up to two (2) days of paid leave each calendar year to participate in civic engagement opportunities and/or volunteer with their chosen community or religious organization.

Additional Benefits

NEW! Minnesota Paid Family & Medical Leave (MN PFML)

Effective January 1, 2026, Augsburg University employees who work more than 50% of the time in Minnesota are entitled to Paid Family and Medical Leave (PFML) under the Minnesota Paid Leave law. This program has been put in place by the State of Minnesota and provides partial wage replacement to employees who take leave from work for qualifying family or medical reasons. The Augsburg private plan will be administered by Unum.

The PFML program is separate from, but will run concurrently and in conjunction with, other leave entitlements such as the federal Family and Medical Leave Act (FMLA), Augsburg's Short-Term Disability, and any other leave programs.

Eligibility

All employees who live and work at least 50% of the time in Minnesota and have earned sufficient wages to qualify under the state program are eligible for PFML benefits. Eligibility is determined by Unum in accordance with the rules set in place by the Minnesota Department of Employment and Economic Development (DEED).

Covered Leave Reasons

Employees may apply for PFML benefits for the following reasons:

- **Medical Leave** – For the employee's own serious health condition* that prevents them from working.
- **Family Leave** – To care for a family member with a serious health condition*.
- **Bonding Leave** – To bond with a new child after birth, adoption, or foster placement.
- **Safety Leave** – To address issues related to domestic abuse, sexual assault, or stalking.
- **Qualifying Exigency Leave** – For certain military family reasons.

Benefit Amount and Duration

Employees can receive up to **12 weeks** of paid benefits for their own serious health condition and up to **12 weeks** for family leave, **with a combined maximum of 20 weeks per benefit year.**

Intermittent leave is allowed under PFML.

Benefit amounts are based on a percentage of the employee's average weekly wage, as determined by Unum (in accordance with state requirements), with a cap set annually.

Calculations of eligible benefits are below:

- 90% of employees' wages not exceeding 50% of the State Annual Weekly Wage (SAWW); plus
- 66% of employees' wages that exceed 50% of the SAWW but not 100%; plus
- 55% of wages that exceed 100% of the SAWW

Note: *MN SAWW as of 10/1/2025 is $1,423*

Funding and Contributions

The program is funded through payroll taxes shared between employers and employees. The state rate is 0.88% of earnings which dictates the maximum employee portion that can be charged.

Employers may deduct up to 50% of this premium from employees' wages. Augsburg employees will be charged 0.44% of bi-weekly wages (deducted over 24 pay periods). Augsburg will cover the remaining costs.

Application for Benefits

Employees must apply directly to Unum for benefits. Unum, not Augsburg, makes the final determination of eligibility and payment amount. Employees should notify both the Unum and Augsburg Human Resources as soon as possible when a qualifying leave is needed.

* *Per MN Statutes § 268B.01, subd. 44, which governs the PFML, a "Serious health condition" is defined as a physical or mental illness, injury, impairment, condition, or substance use disorder that involves:*
(1) inpatient care in a hospital, hospice, or residential medical care facility; or
(2) continuing treatment or continuing supervision by a health care provider.

Additional Benefits

Employee Assistance Program (EAP)
(for Medica members)

The Employee Assistance Program available through Optum is an excellent source for confidential support, expert information and valuable resources, when you need it the most. You have access 24/7 to master's-level clinicians. Counselors have a wide range of expertise to assist you, including specialty teams for tobacco and gambling problems. Management consultation counselors are also available to help with workplace issues.

When appropriate, Optum will connect you with a local counselor who can address your concerns in person. You have access to five face-to-face visits covered at 100% per issue, per year. If you need additional assistance, the counselors can help you get care through your Medica health plan or refer you to affordable community resources.

For more information or to speak to a clinician, call Optum at **800.626.7944**.

Employee Assistance Program (EAP)
(through Unum)

The employee assistance program through Unum (provided by HealthAdvocate) provides employees access to counselors and services for help with personal, family and work issues including stress, depression, anxiety, relationship issues, divorce, job stress, work conflicts, family and parenting problems, anger, grief and loss, addiction, eating disorders and mental illness. The EAP offers 24/7 access to master's level staff clinicians for information, assessment, short-term problem resolution and referrals, and up to 3 face-to-face counseling sessions. In lieu of face to face sessions, HIPAA compliant video counseling sessions are offered for those who prefer the use of technology to receive the service. Employees may call **1.800.854.1446** (multi-lingual) to be referred to a local counselor. These resources may also be accessed online at **www.unum.com/lifebalance**.

Travel Assistance
(through Unum)

Active, benefit-eligible faculty and staff enrolled in the University's life insurance plan are members of Assist America and are entitled to the following services when traveling 100+ miles from home:

- Medical consultation, evaluation, and referral.
- Hospital admission guarantee.
- Lost prescription assistance.
- Emergency medical evacuation.

Wellbeing Program

Augsburg continues to offer a comprehensive employee wellbeing program. Augsburg's Total Wellbeing Program, awarded a 2017 Silver + Green Designation by Hennepin County, offers a variety of activities that encompass physical health, emotional and mental well-being, and financial wellness. Augsburg's wellbeing program also incorporates sustainability and transportation initiatives, as they relate to wellness, to support employee health and the University's work in sustainability.

Medical Bill Saver
(*through HealthAdvocate*)

Augsburg faculty and staff have access to experienced negotiators who can assist with confusing and difficult medical bills. Using fee benchmarking databases to help reduce non-covered medical and dental bills that exceed $400 (regardless of insurance or benefit status), this team will contact doctors, dentists, hospitals and other providers on employees' behalf to negotiate discounts on the balance due and/or create payment plans. Call **1.800.854.1446** to learn more!

Will Prep & Life Planning Services
(*through Unum EAP*)

Your Unum EAP benefit includes access to the simple tools needed to create a basic will. The work-life balance website also provides additional information about the following end-of-life topics, which you may wish to consider in drafting your will:

- Estate planning.
- Advance directive or living will.
- Power of attorney.
- Final arrangements memorandum.

To access the Personalized Legal Center, Visit **www.unum.com/lifebalance**, click "Access Benefits", and select "Legal", or call **1.800.854.1446**.

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)**.

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

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

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

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

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

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

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

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

Paperwork Reduction Act Statement

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

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

Updated CHIP notices can be downloaded **here.**

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

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, 2024 for coverage starting as early as January 15, 2026.

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 9.02% for 2025 and 9.96% for 2026 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 contribution, as well as your employee contribution to employment-based 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. The Augsburg Human Resources Department is also available for additional questions or concerns that you may have. Please call **612.330.1058**

Benefit	Carrier / Administrator	Contact Information	Information Available
Medical Plans Group Numbers: Passport, Low Ded. - 48642 Passport, High Ded. + HSA - 48645 VantagePlus, Low Ded. - 48644 VantagePlus, High Ded + HSA - 48647 Park Nicollet & HP First, Low Ded. - 48643 Park Nicollet & HP First, High Ded + HSA - 48646	Medica Member Services	800.952.3455 *Additional resources located on the back of your ID card* www.Medica.com/SignIn	• 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
Virtual & Home Visits	Kavira	Call or text 763.373.3856 www.kavirahealth.com	• Chat with a nurse practitioner via text or video chat • Schedule a home visit
Spending / Savings Accounts Health Savings Account (HSA) Flexible Spending Accounts (FSAs) - Health Care or Limited Purpose - Dependent Care	Chard-Snyder	800.982.7715 www.chard-snyder.com	• View your account balance and activity • Speak with a service representative • Access account information • Access and submit reimbursements • Search eligible expenses
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
Life & AD&D **Long-Term Disability** **MN PFML**	Unum	866.679.3054 www.unum.com/employees	• Speak with a claim representative or file a claim online • Learn about how your coverage works
Pet Insurance	Nationwide	800.540.2016 www.petinsurance.com/augsburg	• View plan information • Speak to a customer care representative • Submit a claim and check claim status
Employee Assistance Program (EAP)	Unum / HealthAdvocate	1.800.854.1446 www.unum.com/lifebalance	• EAP Counseling • Work/Life Balance • Medical Bill Saver
	Optum EAP	800.626.7944	• EAP Counseling • Work/Life Balance • Depression & Anxiety Assistance
Retirement Plan	TIAA	800.842.2252 www.tiaa.org	• Update beneficiary information • Change investment allocations • Check account balances