2023 | Benefits Resource Guide (COBRA)

AUGSBURG UNIVERSITY

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.

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. Beginning January 1, 2023, Augsburg's medical benefit will be insured by Medica. You will continue to be offered two medical plans now with three 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.

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 $1,250 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, 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.

High Deductible + HSA Plan

For in-network expenses, the deductible is $3,000 per person and $6,000 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.

Medical Premiums

Low Deductible Plan

	Your Monthly Cost for COBRA	
Network	Passport	Park Nicollet & HP First AND VantagePlus
Employee Only:	$797.77	$678.11
Employee + Child(ren):	$1,348.27	$1,146.02
Employee + Spouse/Partner:	$1,834.91	$1,559.67
Family:	$2,632.69	$2,237.79

High Deductible + HSA Plan

	Your Monthly Cost for COBRA	
Network	Passport	Park Nicollet & HP First AND VantagePlus
Employee Only:	$698.86	$594.04
Employee + Child(ren):	$1,181.10	$1,003.94
Employee + Spouse/Partner:	$1,607.41	$1,162.29
Family:	$2,306.28	$1,960.34

These premiums include the 2% COBRA administration fee.

AUGSBURG UNIVERSITY

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 715,000 providers and more than 5,400 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 includes 3,500 primary and specialty care physicians, 650 clinics, and 15 hospitals in the Twin Cities metro and surrounding areas.

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.*

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.

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	$1,250 Single $2,500 Family	$3,000 Single $6,000 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	$6,000 Single $12,000 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 (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 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.

Fit Choices by Medica Program
Workout 12 times per month at a participating fitness club and you can earn up to $20 per month. That's up to $240 a year. A maximum of two $20 credits per month. Eligible members must be 18 years of age or older to receive the membership credit. To learn more about Fit Choices℠ or to find a health club near you, go to **Medica.com/FitChoices**.

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. Each visit is $64 or less, depending on your plan's coverage for virtual care.
- Behavioral health care services including therapy and psychiatry. Cost per visit varies by 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 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** Phone: Call 844-SEE-DOCS (**844-733-3627**)
2. Select a doctor and follow the prompts to start your visit.
3. The doctor will review your history, answer questions, diagnose, treat and prescribe medication (if needed).
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 coverage for prescription drugs.

Virtuwell

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

Services

- Treatment of common medical conditions. Each visit is $59 or less, 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** to create an account and start your online visit.
2. Take a quick online interview that checks your medical history and makes sure your problem can be treated online.
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 coverage for prescription drugs.

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

* Virtual care is different than receiving care via telemedicine. With telemedicine, you go to a doctor's office or other health care facility and connect with a provider at another location using the phone, internet or another means.

** To check your plan's coverage for behavioral health, log on to **Medica.com/SignIn**, select "Look Up My Benefits" and click on "Coverage Documents". Look for "office visit" under the "Behavioral Health – Mental Health" section.

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

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 Monthly Cost for COBRA	
Employee Only:	$42.51
Employee + Child(ren):	$116.56
Employee + Spouse/Partner:	$77.09
Family:	$151.64

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 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 Monthly Cost for COBRA	
Employee Only:	$4.41
Employee + Child(ren):	$8.80
Employee + Spouse/Partner:	$8.36
Family:	$12.94

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/healthcare-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

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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)

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, 2022 for coverage starting as early as January 15, 2023.

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 9.61% for 2022 and 9.12 for 2023 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. 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
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