



20  
24

PLAN  
YEAR



ANDERSON  
UNIVERSITY

# Enrollment GUIDE





# ANDERSON UNIVERSITY



## Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

## Important Contact Information

Carrier	Group #	Web / Email	Phone
<b>Medical</b> Healthgram Connect Advisor	485	www.healthgram.com	1-980-201-3020
<b>Prescription</b> TrueScripts	99995672	www.truescripts.com	1-844-257-1955
<b>Health Savings Account Flexible Spending Accounts</b> Flex Administrators		www.flexadministrators.com	1-800-968-3539
<b>Dental</b> Delta Dental	sc2307- 1000	www.deltadentalsc.com	1-800-529-3268
<b>Vision</b> Eyemed	1011465	www.eyemed.com	1-866-804-0982
<b>Basic Life and AD&amp;D Insurance Voluntary Life Insurance Long-Term Disability Voluntary Accident, Critical Illness</b> Mutual of Omaha	G000BCDS	www.mutualofomaha.com	1-800-769-7159
<b>Retirement Plan</b> Guidestone Retirement		www.guidestone.org	
<b>Employee Assistance Program (EAP)</b> Mutual of Omaha		www.mutualofomaha.com/eap	1-800-316-2796



# Welcome to your 2024 Employee Benefits!

Anderson University takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

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PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Anderson University reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

# Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

## When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month following your date of hire. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

## Eligible Dependents

Your dependents are eligible to participate in Anderson University's benefit plans. Your eligible dependents include\*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

*\*Additional carrier conditions may apply and may vary by state.*

## Newly Hired / Eligible Employees

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage. Coverage, if elected, will begin on the first of the month following your date of hire or on the first if that is your hire date, provided you enroll online within **30 days of your date of hire**.



## Pre-Tax Benefits: Section 125

Anderson University's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

**Pre-tax Note:** When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.





If you have a life event status change, you will need to enter the change in Workday within 30 days of the change. Contact HR with any questions.



# Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.



# Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
<b>New Hire:</b>	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
<b>Marriage:</b>	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
<b>Divorce:</b>	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
<b>Birth or adoption of a child:</b>	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to update the information in Workday.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
<b>Death of a spouse or dependent:</b>	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
<b>Your spouse gains or loses employment that provides health benefits:</b>	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
<b>Loss of coverage with a spouse:</b>	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
<b>Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):</b>	Change your elections within 30 days from the employment status change in order to receive State Continuation information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in State Continuation. Full-time employees will have to wait until the annual Open Enrollment period.

## If you Experience a Life Event Status Change

**You must update your elections within 30 days** of your life event status change or you will not be able to make changes until the next annual open enrollment. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, please contact your Human Resources Department.

# Medical Coverage

Anderson University is proud to offer you a choice between two different medical plans. Coverage under both plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

## Traditional PPO

A Preferred Provider Organization (PPO) offers you the freedom to receive care from any provider—in or out of your network. This means you can see any doctor or specialist, or use any hospital.

In addition, PPO plans do not require you to choose a Primary Care Physician (PCP) and do not require referrals. For example, if you already have a doctor you like, you can continue receiving care from that provider.

If you need to see a specialist, you do not have to first consult with a PCP. No referrals are required for any doctor, specialist or hospital.

A traditional medical plan offers first dollar copays for office visits and prescription drugs. While larger medical expenses go towards your deductible and coinsurance.

## HDHP with HSA

The High Deductible Health Plan (HDHP) functions like a Preferred Provider Organization (PPO), but features a low monthly premium in exchange for a higher deductible. The benefit of this plan is that you will be eligible to enroll in and contribute to a Health Savings Account (HSA). With an HSA, your contributions are pre-tax so any amount you contribute is deducted from your taxable income at the end of the year. The money in your HSA can be spent on eligible healthcare expenses including copays, prescriptions, dental treatment, and more.

As with a PPO, both you and your family can see any health care provider, including specialists, without a referral. You are not required to choose a primary care physician.

Under a HDHP, all covered expenses are applied towards your plan's deductible. Once you satisfy your deductible, the plan will begin paying.

## Out-of-Network Providers

You may choose to seek care outside the Cigna network without a referral, however you will pay a higher deductible and coinsurance for care received from an out-of-network physician, facility or other health care professional. In addition, the plan only pays a portion of those charges and it is your responsibility to pay the remainder if you choose to seek care outside the network. The amount you are required to pay, which could be significant, contributes to a separate out-of-network out-of-pocket maximum. It's recommended that you ask the out-of-network physician or health care professional about their billed charges before you receive care.



## Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

### 1. Know what's important to you in a physician.

If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.

### 2. Get your doctor familiar with your health history.

Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.

### 3. Ask the right questions to build rapport and get on the road to better health.

To maximize the time you have together, write down your health questions for your physician beforehand.

# Medical Plan Comparison

	Traditional PPO In-Network, You Pay:	HDHP with HSA In-Network, You Pay:
<b>Annual Deductible</b> (Individual / Family) *Per IRS & HSA rules a single deductible of \$3,200 applies with a family maximum of \$4,000	<b>\$1,500 / \$3,000</b>	<b>\$2,000 / \$4,000</b> \$3,200 embedded*
<b>Out-of-Pocket Max.</b> (Individual / Family)	\$7,900 / \$15,800	\$4,500 / \$9,000
<b>Preventive Care</b>	100% covered	100% covered
Primary Care Provider	\$20 copay	Deductible, then 30%
Specialist	\$40 copay	Deductible, then 30%
<b>Urgent Care</b>	\$40 copay	Deductible, then 30%
<b>Emergency Room Care</b> *copay waived if admitted	\$275 copay, then 30%*	Deductible, then 30%
<b>Inpatient Hospital Services</b>	Deductible, then 30%	Deductible, then 30%
<b>Outpatient Hospital Services</b>	Deductible, then 30%	Deductible, then 30%
<b>Maternity</b>		
Routine Maternity Physician Services	Deductible, then 30%	Deductible, then 30%
Childbirth / Delivery	Deductible, then 30%	Deductible, then 30%
<b>Diagnostic X-ray &amp; Lab</b> (not associated with office visit)	Deductible, then 30%	Deductible, then 30%
<b>Retail Prescriptions</b> (30-day supply)		
Generic	\$15 copay	Deductible, then 30%
Brand Preferred	\$50 copay	
Brand Non-preferred	\$70 copay	
<b>Mail Order Prescriptions</b> (90-day supply)		
Generic	\$15 copay	Deductible, then 30%
Brand Preferred	\$100 copay	
Brand Non-preferred	\$175 copay	
Specialty (Must be obtained from Specialty Pharmacy and only a 30 day supply)	\$150 copay	
	<b>Out-of-Network, You Pay:</b>	<b>Out-of-Network, You Pay:</b>
<b>Out-of-Net. Deductible</b> (Individual / Family)	\$3,000 / \$6,000	\$7,500 / \$15,000
<b>Out-of-Net. Out-of-Pocket Max</b> (Individual / Family)	\$8,000 / \$16,000	\$12,500 / \$25,000
<b>Co-insurance amount you pay for most services</b>	Deductible, then 50%	Deductible, then 50%

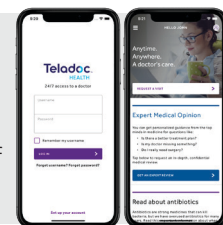
This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost	Traditional PPO		HDHP with HSA	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
<b>Employee Only</b>	\$432.74	\$199.73	\$170.00	\$78.46
<b>Employee + Spouse</b>	\$1,021.22	\$471.33	\$660.00	\$304.62
<b>Employee + Child(ren)</b>	\$843.84	\$389.46	\$550.00	\$253.85
<b>Family</b>	\$1,229.42	\$567.42	\$800.00	\$369.23

## Virtual Visits

Anderson University has partnered with Teladoc to provide you with 24/7/365 on-demand access to a national network of U.S. board-certified doctors through the convenience of phone, video or mobile app visits. Teladoc doctors can diagnose, treat and prescribe medication, when necessary, for a variety of issues. It's more convenient access to quality healthcare, when and where you need it.

Teladoc  
HEALTH



# Healthgram

## Healthgram Member Portal

### Your one-stop resource for:

- ✓ Viewing claims and online EOBs
- ✓ Comparing healthcare costs
- ✓ Tracking program compliance
- ✓ Your Personal Health Record
- ✓ Finding an in-network doctor
- ✓ Helpful wellness resources

### To register for your Member Portal, follow these simple steps:

- 1 Visit [members.healthgram.com](https://members.healthgram.com)
- 2 Click the "Need to Register?" link directly below the login button.
- 3 Enter the required security information.
- 4 When registration is complete, you will be routed back to the home screen.
- 5 Simply enter your username and password and login!

## Connect to an Advisor

Healthgram Connect aligns you with a knowledgeable Health Advisor. Your Advisor is supported by a team of medical and benefits experts and are ready to answer any questions you have about your benefits or care. That means everything from network questions to appointment scheduling to billing.



### Save on healthcare costs

Call before any healthcare procedure to get the right care for the right price.



### Understand your benefits

Get answers to your benefits and billing questions the first time you ask.



### Get rewarded

We believe in rewarding smart choices. Call before any procedure to review your options.

### Advisor can help with:

- ✓ Find the right doctor, hospital or facility for your specific needs
- ✓ Resolve insurance-related issues from claims status inquiries to billing
- ✓ Understand your benefits including all coverage questions and issues
- ✓ Estimate medical costs and in some cases, help you earn money
- ✓ Stay healthy with the help of alert reminders for upcoming screenings

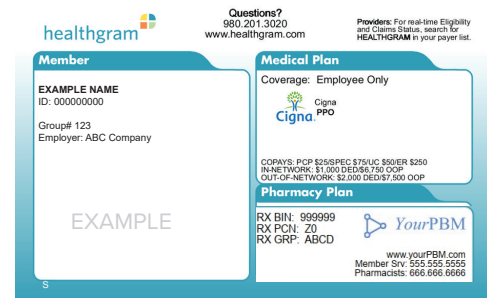
All you need to do is call **866-904-9081** or login to [members.healthgram.com](https://members.healthgram.com).

### IMPORTANT:

If your provider says that you are not covered or you are ineligible for benefits, please confirm that they verified coverage through **Healthgram** and NOT Cigna.

Healthgram provides all benefits and eligibility determinations, NOT Cigna.

To find an in-network provider, view a digital copy of your ID card, or if you still need further assistance, visit your Member Portal to chat with us at [members.healthgram.com](https://members.healthgram.com).



The Cigna logo will be on your insurance card under the "Medical Plan" tab.

**IMPORTANT:** this means that only the medical network is through Cigna. All eligibility, claims, benefits, and support are administered by Healthgram.

healthgram 

### Healthgram Contact:

980-201-3020

[askhealthgram@healthgram.com](mailto:askhealthgram@healthgram.com)

[members.healthgram.com](https://members.healthgram.com).

# Prescription Portal



Scan QR Code or visit  
[memberportal.truescripts.com](https://memberportal.truescripts.com)

## Register for the TrueScripts Member Portal

- Visit [memberportal.truescripts.com](https://memberportal.truescripts.com) or scan the QR code with your mobile device to begin the registration process.
- On the Member Portal landing page, choose “**Register**” from the top navigation bar.
- Enter your personal information to complete the registration process.  
*\*Note that you will need to have your Member ID card readily available.*
- Check your email to verify and complete your account set-up.
- Once inside the portal, quickly access important information and helpful resources from your Member Dashboard. The Drug Price Lookup and Pharmacy Locator tools will help you find the pharmacies nearest you with the best price for your medications.

## Mail Order Member Education

Members may choose to receive prescription medications via mail order pharmacy. This alternative to retail pharmacy is completely optional. Should you wish to enroll in mail order, please follow the steps below, and note that there will be no changes in your plan setup:

1. Select the Mail Order Pharmacy on the provided flyer that you would like to use for your prescriptions. Once you have selected the pharmacy, you will need to contact that pharmacy to setup an account with them. You can complete this step in one of the following methods:
  - a. Set up a profile on their website.
  - b. Call their customer service number
2. Have a list of the medications and prescribing doctors ready to input when asked.
3. Provide the pharmacy with your TrueScripts Processing information:
 

a. RxBin: 017274	c. RxGroup: 99995672
b. RxPCN: PDMI	d. Your Member ID number printed on your card
4. If you have current refills at another pharmacy, you can request that the mail order pharmacy call and request that they be transferred over to your new pharmacy.
5. A new prescription may be needed from your healthcare provider for 90-day fills at the retail pharmacy or mail order. The pharmacy can reach out to your provider to request this script. Since your provider should be able to call this into your pharmacy of choice, an office visit typically will not be required.
6. If the pharmacy informs you that your insurance is not contracted with TrueScripts, please request that they call TrueScripts for us to assist further. You may also call for us assistance.

**Please Note:** The Plan **does not offer** coverage at Walgreens Pharmacy. If you choose to use Walgreens to fill your prescriptions, you will be responsible for the full out of pocket cost.

**Mail Order Pharmacy Network:** To enroll in mail order, please visit a website listed.



343 Mercer Road  
Greenville, PA 16125  
phone: 844-522-2273  
fax: 844-308-1485  
E-Scribe: NCPDP 6005943  
web: [carefilltc.com](https://carefilltc.com)



7835 Freedom Ave NW  
North Canton, OH 44720  
phone: 1-866-909-5170  
fax: 1-866-909-5171  
E-Scribe: NCPDP 3677361  
web: [envisionpharmacies.com/Mail/Patients](https://envisionpharmacies.com/Mail/Patients)



by amazon pharmacy  
250 Commercial St, Suite 2012  
Manchester, NH 03101  
phone: 1-866-332-1668  
fax: 603-935-9108  
E-Scribe: NCPDP 3061582  
web: [pillpack.com](https://pillpack.com)  
*Dispenses 30-day supply only*



P.O. Box 2718  
Portland, OR 97208  
phone: 1-800-552-6694  
fax: 1-800-723-9023  
E-Scribe: NABP 3812674  
NPI 1528003910  
web: [ppsr.com](https://ppsr.com)

\*Care-Fill mail order services are not yet available in the following states: AL, CA, LA, MD, NH, OK, TN, WV

# Wellness & Disease Management

## Purpose:

Anderson University believes employees perform their best when they are healthy. Optimal employee performance is necessary for the University to be a leader in its field. The Wellness and Disease Management Program strives to improve employee health, knowledge and well-being, so serious health conditions can be reduced or prevented.

## Wellness Goals:

### Anderson University's goals for the Wellness & Disease Management Program are to:

- Help employees understand their risk for disease
- Assist employees and spouses in obtaining preventative health services
- Encourage healthy lifestyles
- Support a healthy work environment

The primary means of accomplishing the wellness goals is through individual Health Risk Assessments, followed by review and wellness planning with a nurse. The nurse meets privately with participants once per month on-campus and maintains strict confidentiality in regards to all medical information, as per HIPAA guidelines. This includes not sharing any personal or confidential information with AU administration.

## Incentives for Participation and Compliance:

Anderson University offers incentives for those who choose to participate and comply with the expectations of the Wellness & Disease Management Program. Employees will be eligible to receive up to \$750 contribution per year to their Health Savings Account (HSA) or Flexible Spending Account (FSA) for successful participation and plan compliance and an additional \$200 HSA/FSA contribution for spouse participation. Half the annual incentive is paid to eligible participants in May 2024 and the other half is paid in December 2024.

## Eligibility:

### To be eligible to participate, employees must:

- be enrolled in Anderson University's health insurance plan;
- complete a Health Risk Assessment within 30 days of program eligibility;
- meet with the Wellness Nurse within 90 days of program eligibility, and as directed thereafter;
- provide proof of compliance with the wellness plan outlined by the Wellness Nurse;
- obtain 5 points out of the 13 available points listed on chart;



Complete Health Risk Assessment	1 point
Participate in Wellness Event (scheduled by Wellness committee)	Attend 2 events = 1 point (1 point max per year)
A1C (Glucose) within AMA Recommendations*	1 point
Blood Pressure within AMA Recommendations**	1 point
Cholesterol levels within AMA Recommendations***	1 point
Annual Physical	1 point
Annual Eye Exam or Routine Dental Exam	1 point
BMI of 25 or less****	1 point
Cancer Screening (skin, breast, colon/rectal, prostate, cervical, oral)	1 point
Current Tobacco Cessation participation	3 points

### Documentation is required for point credits and is submitted directly to the Wellness Nurse. Qualifying documentation includes:

- An Explanation of Benefits (EOB) statement
- A completed provider verification form
- Lab results
- Information obtained by the Wellness & Disease Management nurse during a visit (i.e. blood pressure, A1C, cholesterol)

## Important Notes:

- Participation in the Wellness & Disease Management Program is not mandatory. Non-participation does not affect the level of health insurance benefits, but does impact eligibility for incentives.
- A no-call, no-show for an appointment with the Wellness Nurse will result in disqualification from the program.
- Anderson University may amend or repeal any or all of the wellness program at any time as deemed necessary and appropriate.

### American Medical Associations (AMA) recommendations:

\*A1C (Glucose) AMA recommends: Non-Diabetic <5.7%; Diabetic <7.0%, or actively being treated by a physician.

\*\*Blood Pressure AMA recommends: BP <130/80; or actively being treated by a physician.

\*\*\*Cholesterol AMA recommends: Total Cholesterol <200; LDL <100; HDL >39; Triglycerides <150; or actively being treated by a physician.

\*\*\*\*BMI AMA recommends: BMI 18.5-24.9; 25-29.9 is considered overweight; 30 or higher is considered obese.

\*See Important Notice Information concerning the Wellness program in the Annual Notice section of this guide.

# Health Savings Accounts

## Only HDHP with HSA Plan Participants are Eligible

If you enroll in the HDHP with HSA Plan, you are eligible to open and use a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the IRS. The account is similar to a traditional savings account with a debit card. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.



### How You Save With an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed



### HSA Funds Remain Yours to Grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave the company.



### You Can Win With an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.



## Use your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- Over-the-Counter drugs
- Menstrual care products
- Personal Protective Equipment
- and more...

### 2024 HSA Annual Contribution Limits *(Total combined Employee and Employer contribution limit)*

**\$4,150** for individual coverage      **\$8,300** for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional \$1,000 each year.

*Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. <https://www.irs.gov/pub/irs-pdf/p969.pdf>*



# Dental Coverage


## Delta Dental DPPO

The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at [www.deltadentalsc.com](http://www.deltadentalsc.com), or by calling 1-800-529-3268.

Please visit [www.deltadentalsc.com](http://www.deltadentalsc.com) to locate an in network provider. You can choose between providers that are in the PPO or Premier network. Providers in the PPO network offer the best discount and savings for you and your covered dependents.

	PPO In-Network	Premier In-Network	Out-of-Network*
<b>Calendar Year Maximum</b>	\$1,000 per person	\$1,000 per person	\$1,000 per person
<b>Calendar Year Deductible</b> Per Individual / Per Family	\$50 / \$150	\$50 / \$150	\$50 / \$150
<b>Class I Expenses - Preventive &amp; Diagnostic Care</b> Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	100% covered	100% covered	100% covered
<b>Class II Expenses - Basic Restorative Care</b> Fillings, Simple Extractions, Anesthetics, Root Canal Therapy, Repairs (Bridges, Crowns, Inlays and Dentures)	Deductible then, 20%	Deductible then, 20%	Deductible then, 20%
<b>Class III Expenses - Major Restorative Care</b> Crowns, Inlays, Onlays, Dentures, Bridges	Deductible then, 50%	Deductible then, 50%	Deductible then, 50%
<b>Class IV Expenses - Orthodontia</b> Coverage for Eligible Children Only	50%, No Ortho Deductible	50%, No Ortho Deductible	50%, No Ortho Deductible
<b>Orthodontia Lifetime Maximum</b>	\$2,000	\$2,000	\$2,000

*This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.*

 <b>Plan Cost</b>	Delta Dental DPPO	
	Monthly	Bi-Weekly
<b>Employee Only</b>	\$18.01	\$8.31
<b>Employee + Spouse</b>	\$34.51	\$15.93
<b>Employee + Child(ren)</b>	\$51.42	\$23.73
<b>Family</b>	\$67.92	\$31.35

### \*Out-of-Network Providers & Balance Billing

Under the Delta Dental DPPO, the plan pays the same amount to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can “balance bill” you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

# Vision Coverage



## Eyemed Vision Plan

As a vision care member, you'll receive access to great eye doctors, quality eyewear and lower out-of-pocket costs. To find an in network provider, visit [www.eyemed.com](http://www.eyemed.com) or call 1-866-804-0982. At your appointment, tell them you have coverage with the carrier.

There is no ID card necessary. The carrier will handle the rest—there are no claim forms to complete when you see a in network vision provider!

	Description	Copay	Frequency
<b>WellVision Exam</b>	Focuses on your eyes and overall wellness	\$10	Every 12 months
<b>Prescription Glasses</b>		\$25	
<b>Frame</b>	\$130 allowance for a wide selection of frames	Included in Prescription Glasses	Every 24 months
<b>Lenses</b>	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
<b>Lens Options</b>	Standard progressive lenses Premium progressive lenses Custom progressive lenses	\$90 \$110 - \$135 \$90, 20% off balance	Every 12 months
<b>Contacts</b> (instead of glasses) Elective Medically Necessary	\$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to \$40	Every 12 months
<b>Extra Savings</b>	<p><b>Glasses and Sunglasses:</b> 40% savings on additional glasses; 20% off non-covered items including prescription sunglasses.</p> <p><b>Retinal Screening:</b> Up to \$39 covered on routine retinal screening as an enhancement to a WellVision Exam.</p> <p><b>Laser Vision Correction:</b> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.</p>		

### Out-of-Network Provider Coverage:

Visit [www.eyemed.com](http://www.eyemed.com) for details, if you plan to see a provider other than a network provider.

Exam . . . . .	up to \$40	Lined Bifocal Lenses . . . . .	up to \$50	Elective Contacts . . . . .	up to \$130
Frame . . . . .	up to \$91	Lined Trifocal Lenses . . . . .	up to \$70	Med Necessary Contacts . . .	up to \$210
Single Vision Lenses . . . . .	up to \$30	Lenticular Lenses . . . . .	up to \$70		

*This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.*

Plan Cost	Vision Plan	
	Monthly	Bi-Weekly
<b>Employee Only</b>	\$2.55	\$1.18
<b>Employee + Spouse</b>	\$4.84	\$2.23
<b>Employee + Child(ren)</b>	\$5.09	\$2.35
<b>Family</b>	\$7.49	\$3.46

# Flexible Spending Accounts



## Eligibility Based on Medical Plan Election

Flexible Spending Accounts (FSAs) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. Employees need not be enrolled in either medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

	HSA Participants	Non-HSA Participants	
Health Care FSA	✗	✓	<b>Employee-funded.</b> Can use funds for all healthcare related expenses. Federal regulations do not allow participation in an HSA and this type of account.
Dependent Care FSA	✓	✓	<b>Employee-funded.</b> Can use funds for all dependent care related expenses such as day care, nursery school, or elder care.

**HCFA Annual Contribution Limit:**  
**\$3,050**

## Health Care Flexible Spending Account (HCFA)

**Federal regulations do not allow participation in an HSA and this type of account.** Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

**DCFA Annual Contribution Limit:**  
**\$5,000**

## Dependent Care Flexible Spending Account (DCFA)

You may use pre-tax dollars from your DCFA to pay expenses for care when the services enable you and your spouse to work. These include expenses for the custodial care of a dependent child, spouse or elderly parent (provided they are your tax dependents). Also included are baby-sitters, nursery schools, and day care centers.

**Or \$2,500 if you are married and file a separate tax return.**

Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.



The FSA Plan Year is January 1 until December 31.

## “Use it or lose it” FSA Rollover Provision - HCFAs only

Anderson University has elected to participate in the FSA rollover provision, allowing employees to rollover up to \$610 from one plan year to the next. You must be enrolled in an HCFA both plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

# Basic Life | AD&D Insurance

## Basic Life Insurance

Life insurance provides financial protection for your family in the event of your passing. Anderson University offers all employees life and accidental death and dismemberment insurance through Mutual of Omaha.

**Basic Life Benefit Amount:** up to 1.5x annual salary

**Guaranteed Issue:** \$200,000

**Maximum Benefit:** \$350,000

**Basic Spouse Life Benefit:** \$2,000

**Basic Child Life Benefit:** \$2,000 6 months to age out  
\$500 14 days to 6 months

Your benefit amount will reduce by 67% at age 70; 50% at age 75. Benefits terminate upon retirement.

The rate is \$0.18 per \$1,000 of benefit amount. **The University pays 50% of this cost on behalf of each employee.**

**Dependent life is \$0.85 per unit and is paid for by the employee.**

# Voluntary Life | AD&D Insurance



## Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Mutual of Omaha. Please note in certain circumstances evidence of insurability may be required. This coverage comes in the following increments:

### Employee Voluntary Life | AD&D Insurance

**Benefit Amount:** increments of \$10,000

**Guaranteed Issue:** \$100,000

**Maximum Benefit:** the lesser of 5x Annual Base Earnings or \$500,000

### Spousal Voluntary Life | AD&D Insurance

**Benefit Amount:** increments of \$5,000

**Guaranteed Issue:** \$50,000

**Maximum Benefit:** Lesser of \$250,000 or 100% of employee election.

### Dependent Child Voluntary Life | AD&D Insurance

**Benefit Amount:** increments of \$2,500

**Guaranteed Issue:** 100% of employee election up to \$25,000

**Maximum Benefit:** Lesser of \$25,000 or 100% of employee election

*Spouse amount has a minimum of \$5k and terminates at employees age 70; child benefit 14 days to 6 months is \$250*

## Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact Anderson University Benefits Helpline.

# Voluntary Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

**Benefits Start After:** 90 days

**Benefit Amount:** 60% of predisability monthly earnings

**Maximum Benefit:** \$100 to \$5,000 / month

**Benefit Duration:** The lesser of 2 years or your SSNRA\* or the Maximum Benefit Period.

*\*Social Security Normal Retirement Age (SSNRA) means Your normal retirement age under the U.S. Social Security Act.*

Rate Calculation (Monthly)	Rate Calculation (Bi-Weekly)
Your salary x .35 (the Mutual of Omaha Rate) / 100 / 12 months / 2 (University pays 50% for you). This equals your monthly premium.	Your salary x .35 (the Mutual of Omaha Rate) / 100 / 26 pay periods / 2 (University pays 50% for you). This equals your Bi-Weekly premium.

## Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

# Employee Assistance Program

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done at **NO COST to you.**

Maintaining your privacy and confidentiality is of the greatest importance. All records, referrals and evaluations are kept private and confidential in accordance with federal and state laws.

## Available Services:

- **Unlimited phone access to master level specialists, 24/7**
- **Up to 3 referrals for face-to-face counseling sessions.** Our national network includes more than 10,000 licensed clinical providers.
- **A 30 minute legal consultation.** You can choose to meet with an attorney by telephone or in-person to discuss legal concerns. You can also retain an attorney for ongoing services at a 25% discounted rate.
- **A 30 minute financial consultation.** Credentialed financial professionals can help discuss estate taxes and other financial matters with you. 25% discount for ongoing financial services for same issue.

## Available Resources and Referrals:

- ~ Current events
- ~ Child or elder care
- ~ Family and Relationships
- ~ Emotional well-being
- ~ Financial wellness
- ~ Legal assistance
- ~ Substance abuse & addiction
- ~ Work and career
- ~ Bilingual article library

Don't delay if you need help.  
 Visit [mutualofomaha.com/eap](https://mutualofomaha.com/eap)  
 or call **1-800-316-2796** for confidential  
 consultation and resource services.

# Voluntary Benefits



The following Voluntary Benefits through Mutual of Omaha can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

Both plans are portable (you can continue coverage if you leave the company) subject to certain conditions and each plan includes a wellness benefit of \$50.

## Accident Insurance

Accident Insurance is designed to help covered individuals meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue so no health questions are required.

**You have the choice of electing a Low Plan or a High Plan.**

The following list are examples of coverage due to an accident and the Benefit Amount that you will be paid.

	Low Plan	High Plan	
	\$150	\$200	Emergency Room
	\$100	\$125	Urgent Care Center
	\$1,000	\$1,500	Ambulance
	\$75	\$100	Initial Physician Office Visit
	\$1,000	\$1,500	Hospital Admission
	\$200/day	\$300/day	Daily Confinement (up to 365 days)
	\$3,000	\$3,000	Fractures (non-surgical)
	\$4,500	\$4,500	Dislocations (non-surgical)
	\$25	\$50	Therapy Sessions (up to 6)

## Critical Illness Insurance

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

**You have the choice of electing coverage in increments of \$5,000 up to \$20,000.**

Amounts are Guaranteed Issue coverage. Your Spouse will be offered 100% and child(ren) will be offered 50% of your benefit amount.

The following list are examples of coverage due to a critical illnesses and the Benefit Amount (BA) that you will be paid.

- Heart Attack:**  
Initial Benefit: 100% of BA
- Alzheimer's Disease:**  
Initial Benefit: 100% of BA
- Coronary Artery Bypass:**  
Initial Benefit: 25% of BA
- Heart Valve Surgery:**  
Initial Benefit: 25% of BA
- Invasive Cancer:**  
Initial Benefit: 100% of BA
- Bone Marrow Transplant:**  
Initial Benefit: 50% of BA

# 403(b) Retirement Plan

403(b) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

## Eligibility

There is no waiting period. You can enroll at any time. Your enrollment will be effective as soon as administratively possible.

## Employee Contributions

Contributions from your pay are made on a pre-tax basis from 1% to 75% of your compensation – up to the IRS annual limit of \$22,500. If you are 50 years of age or older (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

## Employer Contributions

Anderson University contributes 8% into the Retirement Plan on your behalf. This contribution is NOT based on a match nor does it require you to participate in a contribution.

## For More Information

Set up your investment elections and select/update your Plan beneficiary at [www.guidestone.org](http://www.guidestone.org).

## Additional Features

- **A broad range of investment options.** Target Date Funds, Asset Allocation Funds and Select Funds available to help you decide which approach works best for your life.
- **An account you can take with you.** Should you leave the company, your vested balance is yours to take with you.



## Starting earlier can pay off

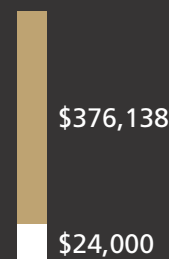
It's important to save enough for your future, and it's also important to understand the concept of compounded returns. The chart shows how starting earlier puts compounding to work for you over time.\*

## Save \$200 a month:

### Start now

Save for 10 years

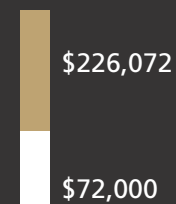
\$400,138



### Wait 10 years

Save for 30 years

\$298,072



■ Earnings    ■ Contributions

\*The hypothetical illustration assumes pre-tax contributions made at the beginning of each month and an annual effective rate of return of 8% and reinvestment of earnings (no rate of return is guaranteed). "Start now" assumes that the contributions are invested for 40 years. "Wait 10 years" assumes contributions are invested for 30 years. Results are for illustrative purposes only and are not meant to represent the past or future performance of any specific investment vehicle.

# Additional Benefits

## Paid Time-Off (PTO) Policy

PTO is designed to give employees time needed away from their everyday work schedule. The University values it's employees and recognizes the need for time off for their family and home life.

## Vacation - Staff and 12-month Faculty

- Eligible upon full-time employment
- 10-20 days annually
- Based upon position and length of service
- Paid by the University
- Maximum annual carryover limits apply

## Sick Leave

- Eligible upon full-time employment
- 9-12 days annual accrual depending on position
- 60 days maximum accrual

## Personal (Emergency and Family Illness Only)

- Eligible upon full-time employment
- 4.5-6 days annually
- Paid by the University

## Bereavement

- Eligible upon full-time employment
- Up to 3 days - immediate family
- Paid by the University

## Voting

- Reasonable time to vote in primary and general elections
- Paid by the University

## Jury Duty

- Paid by the University at regular salary or wage rate

## Holiday / Academic Calendar Breaks

- Up to 15 days paid holidays for employees



Please refer to the Employee Handbook for updates to the most current benefit policies.

## Employee Discounts

- Anderson University Dining Services
- Anderson University Outfitters

## Tuition Benefits

- After 1 year of full-time employment, employees, spouses, and dependent children (as defined by FAFSA rules) are eligible to receive a tuition waiver for undergraduate coursework towards their first bachelor's degree.
- An Employee Graduate Tuition Benefit is also available for employees who are pursuing their first master's degree and who meet the criteria for the benefit.

Full tuition benefit information is available in the Employee Handbook, Section 3.19. Certain criteria pertains to each benefit.

## On Campus Services / Privileges

- Thrift Library
- Post Office

## Family Medical Leave

- Eligible after 12 months of service
- Must have worked 1,250 hours in the last 12 months
- Must have a qualifying condition
- Provides 12 weeks of unpaid leave for serious health condition, childbirth or other qualifying conditions
- Military provisions apply
- Paid leave time runs concurrent with FMLA qualifying leave

## Campus Activities

Anderson University employees and family members enjoy professional-quality musical, dance, and theatre productions, as well as, nationally recognized athletic events in basketball, soccer, wrestling, tennis, cross-country & track, volleyball, golf, baseball and softball. Employees and family members are invited to attend events featuring nationally recognized speakers, guest artists, and educators. Children of employees are invited to special holiday events and summer camps.

## Human Resources

### For additional information:

Contact the Human Resources Department at 864-231-2450 or through email at [hr@andersonuniversity.edu](mailto:hr@andersonuniversity.edu).

*Certain benefits for part-time positions may apply.*

# Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

**Allowed Amount:** Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

**Appeal:** A request for your health insurer or plan to review a decision or a grievance again.

**Balance Billing:** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.

**Co-insurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

**Complications of Pregnancy:** Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

**Co-payment:** A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Deductible:** The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

**Durable Medical Equipment (DME):** Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency Medical Condition:** An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

**Emergency Room Care:** Emergency services received in an emergency room.

**Emergency Services:** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Excluded Services:** Health care services that your health insurance or plan doesn't pay for or cover.

**Grievance:** A complaint that you communicate to your health insurer or plan.

**Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health Insurance:** A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**Home Health Care:** Health care services a person receives at home.

**Hospice Services:** Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

**Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**Hospital Outpatient Care:** Care in a hospital that usually doesn't require an overnight stay.

**In-network Co-insurance:** The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

**In-network Co-payment:** A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

**Medically Necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

**Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-Preferred Provider:** A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

**Out-of-Network Co-insurance:** The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

**Out-of-Network Co-payment:** A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

**Out-of-Pocket Limit:** The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

**Physician Services:** Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan:** A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

**Preauthorization:** A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes

called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

**Preferred Provider:** A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

**Premium:** The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

**Prescription Drug Coverage:** Health insurance or plan that helps pay for prescription drugs and medications.

**Prescription Drugs:** Drugs and medications that by law require a prescription.

**Primary Care Physician:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

**Primary Care Provider:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Provider:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

**Reconstructive Surgery:** Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

**Rehabilitation Services:** Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Skilled Nursing Care:** Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

**Specialist:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

**UCR (Usual, Customary and Reasonable):** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

**Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# Annual Notices

## Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

## Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

## Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

## States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

## Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

## Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

# Annual Notices continued...

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## Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

## Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

## Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

## Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

# Annual Notices continued...

## State Continuation

### South Carolina Insurance Code provisions for mandated Benefits are as follows:

SECTION 38-71-770 requires that group policies providing hospital surgical, or major medical expense insurance coverage, or any combination of these coverages, provide continuation of coverage to Employees or members who lost coverage under the group policy for any reason (other than nonpayment of premium) may continue coverage for the fractional policy month plus six (6) months.

### Individuals Eligible for Continuation of Coverage

Continuation is extended to those classes of individuals who were entitled to continuation and conversion under the statute as previously written. Therefore, the continuation privilege extends to (1) Employees and members who lose coverage under the group policy (2) Dependents who lose coverage upon reaching the limiting age (3) spouses and children who lose coverage by death of the Employee or member and (4) spouses and children who lose coverage as the result of ceasing to be qualified as a family member (divorce). If there are instances in which coverage is lost by an individual who does not fit in any of the categories listed above, the Department urges that continuation of coverage nonetheless be offered and that "Employee or member" be construed broadly to cover any individual who was covered under the group policy. As with the prior statute, individuals eligible for other group coverage with similar Benefits or those eligible for Medicare are not entitled to continuation of coverage. In addition, continuation of coverage is not provided by this statute if the individual who loses coverage is eligible for continuation of coverage under federal law for a period in excess of six (6) months.

### Conditions of Eligibility for Continuation

The six-month continuation of coverage provision applies only to Employees and members, or other eligible classes of individuals discussed above, who have been covered under the group policy for at least six (6) months. The full premium for the coverage must be paid by the individual before the date each month that the group policy begins. Continuation of coverage applies only if the group policy or a successor policy remains in force. A successor policy is one with an effective date sixty-two (62) days or less after the date of the termination of coverage by the prior insurer. Therefore, if a group policy replacement occurs and individuals who were insured under the prior policy for at least six (6) months lose coverage, the successor insurer must provide six months continuation of coverage to those individuals.

### Notification of Continuation Privilege

SECTION 38-71-770, as amended, continues to require that the Employer advise the Employee of his right to continuation, of the amount of the premium required for such coverage and of his responsibility to timely pay the premium. Each certificate of

coverage must contain a notification of the privilege to continue coverage. Although not required, the Employer may give written notice to you for your right to continue your group health policy.

### If you elect State Continuation

You will be covered on the same basis as if your employment status had not changed. All premiums required to bring the coverage current must be paid to the Employer upon the election to continue coverage. The coverage shall be reinstated retroactive to the date of termination or loss of eligibility. All subsequent continuation premiums must be paid to the Employer in advance. Also, there is **NO GRACE PERIOD FOR PREMIUM PAYMENTS**; therefore, premiums must be paid on or before each due date.

### Termination

State Continuation will end of the earliest of the following dates:

Six (6) months after the beginning date of state continuation;

The date ending the period for which the continuation participants last makes a premium payment;

The date the continuation participant becomes or is eligible to become covered for similar Benefits under any form of group health coverage;

The date the group policy is terminated.

### The Employer is responsible for:

Offering health insurance continuation to all eligible Employees and Dependents as required by State Law; and

Accepting and remitting premium payments to the insurance company in accordance with plan guidelines.

### The Employee has the right to receive:

- Notification of his or her continuation rights; and
- The opportunity to continue his or her health insurance coverage in accordance with State Law.

### The Employee is responsible for:

Requesting continuation from the Employer;

Paying premiums on time and in a manner satisfactory to the Employer (IMPORTANT REMINDER: THERE IS NO PREMIUM PAYMENT GRACE PERIOD AFTER THE DUE DATE); and

Being aware of all plan guidelines and continuation rules.

**If you wish to elect this coverage, please contact AU Human Resources at 864-231-2061.**

### If you wish to contact the State of South Carolina Insurance Division:

South Carolina Department of Insurance Consumer Service Division: 800-768-3467 (in state only).

# Wellness Notice

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## Important Notice About Your Wellness Program

The Anderson Wellness & Disease Program is voluntary and available to all employees on the health plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others.

Various health assessments and screenings are available and voluntary as a part of the wellness program. You are not required to complete these or other medical examinations. However, employees who choose to participate are eligible for rewards. The health testing and assessment options that are either a part of or encouraged by the wellness program include a health risk assessment, participation in a Wellness committee event, annual physical, eye exam or dental exam, cancer screening, biometric screening of blood pressure, cholesterol lipid panel, glucose (blood sugar) and body mass index and tobacco cessation counseling. If you think you might be unable to meet the standard for the reward under this wellness program or for program alternatives, contact HR and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

The information from the health testing can help you understand your current health and potential risks, and determine appropriate lifestyle goals. You also are encouraged to share your results or concerns with your own doctor.

## Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Anderson University may use aggregate information to design a program based on identified health risks in the workplace. Your physician and the vendors who administer and provide screenings will not disclose any of your personal information either publicly or to the employer, except as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. In addition, all health information obtained through the wellness program will be maintained separately from your personnel records, stored electronically and encrypted, and not be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You will not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor will you be subjected to retaliation if you choose not to participate.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving a reward. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Anderson University may be provided with an aggregate report (summary of results with no identifying information) or a list of names of participants for programs where participation is tracked for the purposes of distributing rewards.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation contact HR.

# 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](http://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](http://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](http://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, 2023. Contact your State for more information on eligibility –

**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](mailto:CustomerService@MyAKHIPP.com)  
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

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

**CALIFORNIA** – Medicaid  
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](mailto:hipp@dhcs.ca.gov)

**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://hncpf.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

**FLORIDA** – Medicaid  
Website: <https://www.flmedicaidptrecovery.com/flmedicaidptrecovery.com/hipp/index.html>  
Phone: 1-877-357-3268

**GEORGIA** – 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

**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: <https://www.in.gov/medicaid/>  
Phone: 1-800-457-4584

**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  
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>  
HIPP Phone: 1-888-346-9562

**KANSAS** – Medicaid  
Website: <https://www.kancare.ks.gov/>  
Phone: 1-800-792-4884  
HIPP Phone: 1-800-967-4660

**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: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov)  
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>  
Phone: 1-877-524-4718  
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

**LOUISIANA** – Medicaid  
Website: [www.medicicaid.la.gov](http://www.medicicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

**MAINE** – Medicaid  
Enrollment Website: [https://www.mymaineconnection.gov/benefits/s/?language=en\\_US](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

**MASSACHUSETTS** – Medicaid and CHIP  
Website: <https://www.mass.gov/masshealth/pa>  
Phone: 1-800-862-4840 TTY: 711  
Email: [masspreassistance@accenture.com](mailto:masspreassistance@accenture.com)

**MINNESOTA** – Medicaid  
Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>  
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  
Email: [HSHIPPProgram@mt.gov](mailto:HSHIPPProgram@mt.gov)

**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://dhcnp.nv.gov>  
Medicaid Phone: 1-800-992-0900

**NEW HAMPSHIRE** – Medicaid  
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. 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/](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: <https://www.hhs.nd.gov/healthcare>  
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>  
Phone: 1-800-699-9075

**PENNSYLVANIA** – Medicaid and CHIP  
Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>  
Phone: 1-800-692-7462  
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)  
CHIP Phone: 1-800-986-KIDS (5437)

**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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services  
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access  
Phone: 1-800-250-8427

**VIRGINIA** – Medicaid and CHIP  
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  
Website: <https://www.hca.wa.gov/>  
Phone: 1-800-562-3022

**WEST VIRGINIA** – Medicaid and CHIP  
Website: <https://dhr.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  
Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>  
Phone: 1-800-362-3002

**WYOMING** – Medicaid  
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, 2023, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

# Health Insurance Marketplace

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The Patient Protection Affordability Care Act (“PPACA”) was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or they may be required to pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families>.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace (“Marketplace”), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage, with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in Anderson University's medical plan, then PPACA may have little effect on you. Anderson University's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by Anderson University, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See <https://www.healthcare.gov/have-job-based-coverage/>).

If you are not eligible to enroll in Anderson University's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: [healthcare.gov](http://healthcare.gov)).

## How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit [healthcare.gov](http://healthcare.gov) or call 1-800-318-2596.

