UNIVERSITY OF ST. THOMAS

2023 BENEFIT ENROLLMENT GUIDE

Table of Contents

A Message to our Employees

Dear St. Thomas faculty and staff,

Open enrollment for 2023 is officially right around the corner (Oct. 31-Nov. 11), and this year we have some very important updates to share: Effective Jan. 1, 2023, the University of St. Thomas will switch health insurance providers and begin a new partnership with UnitedHealthcare. More details are included in this note, but there are two critical things to know immediately:

- First, we are happy to report this new partnership means **there will be no insurance premium rate changes** for 2023.
- Secondly, **all benefit-eligible employees will be required to review, enroll or decline all benefit elections for 2023**, including flexible spending accounts (FSA) or health savings accounts (HSA). Due to the switch, a rollover option isn't available this year, which means **employees who do not enroll by the Nov. 11 deadline will not have health insurance through St. Thomas in 2023.**

We know many of you have immediate questions; here are some additional details behind this change:

What isn't changing?

- **Insurance premiums**. Employees who elect a similar plan and at the same coverage level as their current Blue Cross and Blue Shield of Minnesota plans **will see zero increases in their monthly premiums**.
- Like the Blue Cross and Blue Shield of Minnesota Aware network, the UnitedHealthcare broad network – Choice Plus – will include all the large health care providers – M Health Fairview, Allina Health, HealthPartners, North Memorial Health, etc. The majority of our employees are currently enrolled in a broad network plan.
- All enrollees will still have access to Nice Healthcare, which offers households unlimited virtual and in-home visits in addition to many free prescriptions (and new for 2023, Nice Healthcare will expand services to include employees age 65+).
- All high-deductible plan enrollees remain eligible for the same annual HSA contribution from St. Thomas.

What is changing?

- Employees currently using an Allina Health provider will have access to them only under the UnitedHealthcare Choice Plus plans, which are the broad network plans. This may mean a change for employees in a narrow network plan seeing an Allina Health provider.
- All participating employees will receive new health insurance/medical ID cards from UnitedHealthcare.
    - Enrollees will have access to expanded services and offerings such as Rally (UnitedHealthcare's well-being website and mobile app) and Advocate4Me (a single point of contact to provide an integrated, personal experience to ensure you have support in making informed health care choices). Additionally, some participants will have access to Mayo Clinic services not previously available to them with the Blue Cross and Blue Shield of Minnesota High Value Network plans.

Why are we making this change?

- This decision allows the university to save a substantial amount of money, which in turn allows us to keep costs down for employees next year. In 2023, we were due to face significant cost increases from Blue Cross and Blue Shield of Minnesota. Because we did not want to pass these costs along to our employees, the university solicited bids from other carriers to explore alternatives. A relative newcomer to the Minnesota health care market, UnitedHealthcare priced its coverage very competitively to earn our business. We then sought feedback from staff and faculty representatives, as well as administrative leaders, and made the decision to proceed with UnitedHealthcare's proposal.

How can I get more information?

- Visit OneStThomas during open enrollment for resources to learn about these changes, including:
    - Recorded sessions on an array of topics including Medicare, UnitedHealthcare provider networks, Nice Healthcare and more
        - Consider making an appointment with our benefits team starting Oct. 31
    - Appointment sign-ups will be available on OneStThomas in the coming weeks

Please be on the lookout for additional communications; Murphy Online will be available from Oct. 31–Nov. 11 to complete your elections. As always, please contact us at (651) 962-6510 or humanresources@stthomas.edu with any questions.

Thank you,

Kathy Arnold
Vice President and Chief Human Resource Officer

Eligibility

If you are a benefit eligible employee (.625 FTE), working 25 hours a week or more, you may enroll your spouse and children up to age 26 for certain benefit plans.

- Your spouse is an individual of the same or opposite sex who is legally married to you.
- A child is your biological child, adopted child, stepchild or guardian under the age of 26. It also includes a disabled child over age 26 who has been approved for coverage.

.

IMPORTANT: If you are enrolling a spouse or dependent for the first time under any of the plans, you are required, within 30 days of your enrollment, to provide proof of your relationship to the individual(s) you are enrolling for coverage to the Benefits Office. See Family Member Eligibility Matrix for list of acceptable documents. Failure to provide acceptable documents timely may result in the termination of the affected individual's coverage.

Family Member Eligibility Matrix

If you are covering your:	The plan covers this individual if:	Documentation needed if electing:
Spouse	• The person is currently your legal spouse	**Medical, dental, vision and/or life insurance coverage:** • A copy of your marriage license
Newlywed Spouse	• The person is currently your legal spouse AND • You were married within the last six (6) months.	**Medical, dental, vision and/or life insurance coverage:** • A copy of your marriage license
Natural Born Child to age 26	He or she is: • Your natural born child AND • Within the month during which s/he turns 26 or earlier	**Medical, dental, vision and/or dependent life insurance coverage:** • A copy of the child's birth certificate naming you as the child's parent
Stepchild up to age 26	He or she is: • Your stepchild AND • Within the month during which s/he turns 26 or earlier	**Medical, dental, vision and/or dependent life insurance coverage:** • Verification of Spouse AND • A copy of the child's birth certificate naming your Spouse as the child's parent
Legally Adopted Child / Child Placed for Adoption/ Legal Guardianship to age 26	He or she is: • Your Legally Adopted Child/Child Placed for Adoption or Child in Legal Guardianship AND • Within the month during which s/he turns 26 or earlier	**Medical, dental, vision and/or dependent life insurance coverage:** • A copy of adoption decree or court decree naming you as the child's adoptive parent or guardian AND • A copy of a legal document showing child's age
Grandchild to age 26	He or she is: • Your grandchild • Within the month during which s/he turns 26 or earlier	**Medical, dental, vision and/or dependent life insurance coverage:** • A copy of the grandchild's birth certificate naming your child as the child's parent **AND** • A copy of your child's birth certificate showing you as parent **AND** • A form of documentation showing residency with you such as school or medical records **AND** • A copy of your most recent Federal Income Tax Return showing Grandchild as a claimed dependent
Child covered by a QMCSO	• A child covered under a Qualified Medical Child Support Order.	**Medical, dental, vision and/or dependent life insurance coverage:** • A copy of the QMCSO

Nice Healthcare

Nice Healthcare is a primary care clinic that offers you and your family **unlimited virtual and in-home visits with clinicians**. The University of St. Thomas has covered the majority of these costs, leaving you only responsible for a $5 copay per visit.

Who Can Use Nice?

All of Nice's services, including primary care, mental health, physical therapy, and prescriptions are available to employees and their families. **New in 2023, this includes individuals over age 65.**

The Clinic That Comes to You

Same-Day Chat and Video Visits

Diagnosis, prescriptions, treatment plans, care guidance, referrals, and more – care when you need it from anywhere you happen to be.

In-Home Visits

Need a blood draw, a rapid test, a physical exam, or any other in-person need? Nice will come to you with 35 free labs and physical tests!

Full-Service Prescriptions

Nice integrates with nearly every pharmacy in the country and provides white glove support to make your prescription experience simple. Plus, Nice provides 550 medications for free.

Virtual Physical Therapy

You'll get access to licensed physical therapists who are trained to diagnose and treat virtually, allowing you to get better without the hassle of endless in-person visits.

Virtual Mental Health Therapy

Nice mental health therapists focus on prevention, helping you to self-manage your mild to moderate mental health needs. Don't wait to start feeling better!

In-Home X-rays and EKGs

Nice can send a mobile imaging technician right to your home to conduct x-rays, EKGs.

> It seems to be as great as they made it sound like it was going to be. Overall, I was very pleased with the service and speed with which I got covered. I give them an A+ for service and exceeding my expectations!
>
> -Melissa Barglof-Johnson

> We had a great experience with Nice. The visit was easy to schedule with plenty of available times. The appointment started promptly on time and the staff was very knowledgeable and friendly. We will definitely be using this service again!
>
> -Leigh

> Everyone at Nice has helped to make me feel comfortable and confident that I'm getting the best care possible. It's nice knowing that they have my best interest in mind and go above and beyond to help when needed. Everyone should use Nice!
>
> -Jennifer Bodsgard

When to Use Nice

Routine Checkups:

- Annual Wellness Exam
- Sports Physicals
- Child Checkups

Chronic Care:

- High Blood Pressure
- High Cholesterol
- Thyroid Conditions
- Diabetes

Sick Care:

- Cold/Flu
- Strep Throat
- Sinus & Ear Infections
- UTIs
- Pink Eye
- Rashes

Short-Term Mental Health:

- Anxiety
- Depression
- Grief & Loss

Virtual Physical Therapy:

- Back Pain
- Neck Pain
- Injury Recovery

Imaging:

- X-Rays
- EKGs

35+ Labs:

- Blood Work
- A1c

nice

It All Starts With the App

Use the Nice app to schedule visits, chat with clinicians, attend video visits, review treatment plans, upload documents, and more.

Scheduling a Visit

Whenever you and your dependents need Nice, you'll begin the process by scheduling a virtual visit with a clinician. All virtual services are conducted using the Nice app, including chat and video visits, physical therapy and mental health therapy.

In addition to scheduling and conducting visits, you will also use the Nice app to review treatment plans, upload documents and manage your accounts.

NICE HEALTHCARE'S MINNESOTA SERVICE AREA

- The purple area represents where Nice offers home visits to their patients.
- Employees who live outside of the shaded region can still use any of their virtual services and pharmacy program. They can also have a Nice clinician meet them at their workplace, or a friend/family member's home for an in-person visit if their home is not within their service area.
- Virtual care visits are available from anywhere in the country, as long as you are a resident of a state Nice is medically licensed in.
- To see an interactive map, visit https://www.nice.healthcare/locations, or find the "Locations" page on their website.

The Clinic That Comes To You

We offer our clinician services in parts of Arizona, Colorado, Idaho, Iowa, Minnesota, Nebraska, New Mexico, Nevada, Oregon, Utah, Washington, and Wisconsin.

Online Visit Hours

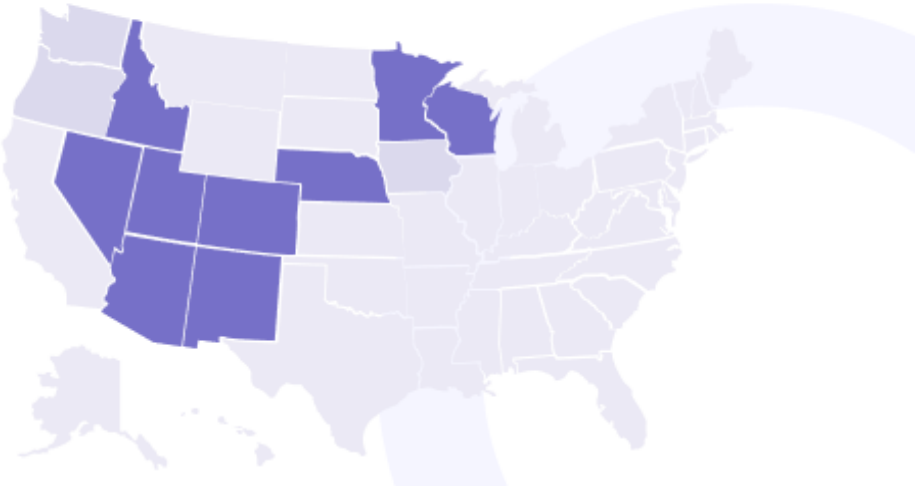
Mon – Fri	8am – 7pm CT
Sat – Sun	9am – 12pm CT
Mon – Fri	7am – 6pm MT
Sat – Sun	8am – 11am MT
Mon – Fri	6am – 5pm PT
Sat – Sun	7am – 10am

Home Visit Hours (local time)

Mon – Fri 9am – 5pm

Virtual Only

Virtual & In-Home



Medical Coverage

Administered by United Healthcare

In 2023, you will continue to have the choice between three different plan designs and two different provider networks, the Choice Plus network and the Core network.

- **THE CHOICE PLUS NETWORK:** The Choice Plus network gives you broad, open access to United HealthCare's largest national network. There are no referrals required and out of network coverage is included.
- **THE CORE NETWORK:** The Core network is a narrower network of top providers in the 11 county metro area and allows for a reduced premium. This network includes providers such as M Health Fairview, North Memorial and several other aligned physician groups. This network does not include the Allina network of providers.

All three medical plan options cover preventive care, catastrophic care, prescription benefits, and include the Mayo Clinic Rochester campus.

Below is a comparison of the **in-network** benefits for each of the three plans. The in-network benefits are the same for both the Choice Plus and Core network.

Visit **www.whyuhc.com/ust** or call the dedicated St. Thomas customer service line at 1-833-404-2190 to search for a provider and learn more about United Healthcare.

	Plan 1	Plan 2	Plan 3
HSA Employer Contribution	**Not Available**	**$500/$600/$600/$1,000**	**$750/$850/$850/$1,250**
Deductible *(Calendar Year)*	$750 Individual $1,500 Family	$3,000 Individual $6,000 Family	$3,250 Individual $6,500 Family
Out-of-Pocket Maximum *(Medical & Rx Combined)*	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Preventive Care	100%	100%	100%
Nice Healthcare *(Virtual & In-Home)*	**$5 Per Visit**	**$5 Per Visit**	**$5 Per Visit**
Retail Clinic	$15 Copay	0% After Deductible	20% After Deductible
Office Visits & Urgent Care	$35 Copay	0% After Deductible	20% After Deductible
Specialty Office Visits	$50 Copay	0% After Deductible	20% After Deductible
In-Patient/Out-Patient	20% After Deductible	0% After Deductible	20% After Deductible
Emergency Room	$150 Copay	0% After Deductible	20% After Deductible
Prescription Drugs	$15/$35/$85	0% After Deductible	20% After Deductible
HSA Preventive Drugs	Not Available	$0 Copay (Preventive Rx)	$0 Copay (Preventive Rx)

2023 Medical Premiums

Bi-weekly Premium Deductions

	Choice Plus Network	Core Network
Plan 1		
Employee	$109.84	$99.50
Employee + spouse	$272.21	$246.59
Employee + child(ren)	$249.52	$226.03
Family	$393.17	$356.16
Plan 2		
Employee	$61.81	$55.44
Employee + spouse	$177.28	$159.01
Employee + child(ren)	$162.50	$145.76
Family	$256.08	$229.69
Plan 3		
Employee	$53.38	$47.93
Employee + spouse	$162.82	$146.19
Employee + child(ren)	$149.24	$133.99
Family	$234.97	$210.96

**Payroll is bi-weekly (26 pay periods), but benefit deductions are taken on the first two pay periods of each month (24 pay periods).*

Pharmacy Coverage

Administered by OptumRx

In 2023, your pharmacy benefit manager will be OptumRx. Your prescription plan will utilize the Flex Base 3-Tier formulary or Prescription Drug list (PDL).

Visit **www.whyuhc.com/ust** where you can see if your drug is on the PDL, estimate drug cost and help find lower tier medications. All plans utilize the same PDL.

In the chart below, overall value indicates medications' effectiveness and safety, cost, and the availability of alternative medications to treat the same or similar medical condition(s).

Drug Tier	Includes	Helpful Tips
Tier 1	$ **Lower-cost** Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
Tier 2	$$ **Mid-range cost** Medications that provide good overall value. Mainly preferred brand-name drugs.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
Tier 3	$$$ **Highest-cost** Medications that provide the lowest overall value.	Ask your doctor if a Tier 1 or Tier 2 option could work for you.

University of St. Thomas
Plan 1 | Group Number# Choice Plus:929440-A/Core: 929440-AC

United Healthcare 2023 Benefit Highlight

	In network Choice Plus | Core	Out of network Choice Plus | Core
Calendar-year deductible The in- and out-of-network maximums cross apply.	$750 individual $1,500 family	$750 individual 1,500 family
Coinsurance Level – What the member pays after the deductible has been satisfied	20% coinsurance	30% coinsurance
Calendar-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges more than the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $4,000 individual $8,000 family	Medical and prescription combined $4,000 individual $8,000 family
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care • well-childcare to age 6 • prenatal care • cancer screening • preventive hearing and vision exams • immunizations and vaccinations	0%	Deductible then 30% coinsurance
Physician services • nice Healthcare • E-visits • physician office visits • professional lab services • office and outpatient lab/X-Ray • allergy injections and serum • specialist office visits and urgent care	$5 Copay 100% $15 Copay 100% $35 Copay 100% Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance $50 Copay 100%	No Coverage Deductible then 30% coinsurance
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy (15 services per person per calendar year) • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy) • acupuncture (24 visit limit per person per calendar year) • home health care	$35 Copay 100% Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 30% coinsurance
• **Hospital Inpatient services**	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	$150.00 Copay 100% Deductible then 20% coinsurance Deductible then 20% coinsurance	

	In network Choice Plus | Core	Out of network Choice Plus | Core
Durable Medical Equipment/Medical Supplies	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Bariatric surgery	No coverage	
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visit/therapy) • outpatient hospital/facility services	Deductible then 20% coinsurance $35 Copay 100% Deductible then 20% coinsurance	Deductible then 30% coinsurance
Prescription drugs – **Retail** (31-day limit) • Tier 1 • Tier 2 • Tier 3 **Mail order pharmacy** (90-day limit) • Tier 1 • Tier 2 • Tier 3	 $15 Copay $35 Copay $85 Copay $37.50 Copay $87.50 Copay $212.50 Copay	 $15 Copay $35 Copay $85 Copay No coverage

Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days' supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills. If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits. For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Riders, and/or Amendments, those documents govern. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

University of St. Thomas
Plan 2 | Group Number# Choice Plus:929440-AD/Core: 929440-AA

United Healthcare 2023 Benefit Highlight

	In network Choice Plus | Core	Out of network Choice Plus | Core
Calendar-year deductible The in- and out-of-network maximums cross apply.	$3,000 individual $6,000 family	$3,000 individual $6,000 family
Coinsurance Level – What the member pays after the deductible has been satisfied	0% coinsurance	30% coinsurance
Calendar-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges more than the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $3,000 individual $6,000 family	Medical and prescription combined $3,400 individual $6,800 family
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care • well-childcare to age 6 • prenatal care • cancer screening • preventive hearing and vision exams • immunizations and vaccinations	0%	Deductible then 30% coinsurance
Physician services • nice Healthcare • E-visits • physician office visits • professional lab services • office and outpatient lab/X-Ray • allergy injections and serum • specialist office visits	$5 Copay 100% Deductible then 0% coinsurance	No Coverage Deductible then 30% coinsurance
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy (15 services per person per calendar year) • home health care • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy) • acupuncture (24 visit limit per person per calendar year)	Deductible then 0% coinsurance	Deductible then 30% coinsurance
• **Hospital Inpatient services**	Deductible then 0% coinsurance	Deductible then 30% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	Deductible then 0% coinsurance	Deductible then 30% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 0% coinsurance	

	In network Choice Plus | Core	Out of network Choice Plus | Core
Durable Medical Equipment/Medical Supplies	Deductible then 0% coinsurance	Deductible then 30% coinsurance
Bariatric surgery	No coverage	
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visit/therapy) • outpatient hospital/facility services	Deductible then 0% coinsurance	Deductible then 30% coinsurance
Prescription drugs – **Retail** (31-day limit) • Tier 1 • Tier 2 • Tier 3 **Mail order pharmacy** (90-day limit) • Tier 1 • Tier 2 • Tier 3	Deductible then 0% coinsurance	Deductible then 30% coinsurance No coverage

Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days' supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills. If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits. For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Riders, and/or Amendments, those documents govern. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

University of St. Thomas
Plan 3 | Group Number# Choice Plus:929440-AB/Core: 929440-AE

United Healthcare 2023 Benefit Highlight

	In network Choice Plus | Core	Out of network Choice Plus | Core
Calendar-year deductible The in- and out-of-network maximums cross apply.	$3,250 individual $6,500 family	$3,250 individual $6,500 family
Coinsurance Level – What the member pays after the deductible has been satisfied	20% coinsurance	30% coinsurance
Calendar-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges more than the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $6,000 individual $12,000 family	Medical and prescription combined $7,000 individual $14,000 family
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care • well-childcare to age 6 • prenatal care • cancer screening • preventive hearing and vision exams • immunizations and vaccinations	0%	Deductible then 30% coinsurance
Physician services • nice Healthcare • E-visits • physician office visits • professional lab services • office and outpatient lab/X-Ray • allergy injections and serum • specialist office visits	$5 Copay 100% Deductible then 20% coinsurance	No Coverage Deductible then 30% coinsurance
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy (15 services per person per calendar year) • home health care • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy) • acupuncture (24 visit limit per person per calendar year)	Deductible then 20% coinsurance	Deductible then 30% coinsurance
• **Hospital Inpatient services**	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance	

	In network Choice Plus | Core	Out of network Choice Plus | Core
Durable Medical Equipment/Medical Supplies	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Bariatric surgery	No coverage	
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visit/therapy) • outpatient hospital/facility services	Deductible then 20% coinsurance	Deductible then 30% coinsurance
Prescription drugs – **Retail** (31-day limit) • Tier 1 • Tier 2 • Tier 3 **Mail order pharmacy** (90-day limit) • Tier 1 • Tier 2 • Tier 3	Deductible then 20% coinsurance	Deductible then 30% coinsurance No coverage

Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days' supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills. If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits. For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Riders, and/or Amendments, those documents govern. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

United Healthcare Tools and Resources

myuhc.com and UnitedHealthcare app

myuhc.com® is your personalized website. It helps you access and manage your health plan and health information. Use it to find network doctors and facilities, check your coverage and claims status, review preventive care services, print a temporary ID card and check your plan balance. You can also download the UnitedHealthcare app® from the App Store® or Google Play™

Rally®

The Rally® digital experience is designed to help you achieve your health goals, and you may earn Rally Coins that you can use for a chance to win rewards. Visit **myuhc.com.**

Personal Health Support

Personal Health Support provides members highly personalized support and guidance to address their health concerns.

- Cancer support services
- Disease management, including asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, and heart failure management
- Congenital heart disease resource services
- Kidney support services
- Transplant resource services

Visit **myuhc.com/phs** to get started.

Cancer Resource Services

Provides patients with information to help them make more informed decisions about their cancer care. Resources include:

- Access to a national network of cancer centers for a second opinion or treatment
- A focus on uncommon and complex cancers where practice variability and expenses tend to be high, although program services and network are available for any type of cancer care

Cancer Support Services

Includes Cancer Resource Services plus:

- Information for ongoing care
- Comprehensive case management to help close gaps in care
- Access to an integrated, multi-disciplinary team (medical doctors, social workers) to help fill gaps in care
- Access to cancer Centers of Excellence (COE) providers and facilities

Premium doctors

Your health plan helps you find a doctor with the UnitedHealth Premium® program. The program identifies those doctors who meet national standards for quality and local market benchmarks for cost efficiency. Go to **myuhc.com** and click on Find a Doctor. Look for the blue hearts.

Behavioral Health

If you need help navigating mental health, financial or legal concerns, take advantage of these resources — included in your health plan at no additional cost.

- **Talkspace:** Access professional counseling via text, audio or video messaging right from your phone or computer. To get started, visit talkspace.com/connect.
- **Self Care by AbleTo:** Self-care, self-improvement and coaching. Download the app from the App Store® or Google Play™ to get started.
- **Live and Work Well:** Self-help, education and resources. Sign in to myuhc.com, then go to Coverage & Benefits > Mental Health.
- **Behavioral Health visits:** Behavioral health treatment, including regularly scheduled therapy appointments. Call 1-844-333-8728 to find a network provider or at myuhc.com > Find a Doctor > Behavioral Health Directory

Maternity Support

Provides expectant mothers with nurse support from pregnancy through postpartum. Visit **myuhc.com.**

Advocate4Me Elite®

Provides members end-to-end health, wellness and benefits support including benefits and claims questions, finding a doctor and scheduling appointments, proactive support and information, health education, clinical program enrollment and much more.

Visit the dedicated University of St. Thomas site at www.whyuhc.com/ust or call 1-833-404-2190 with questions or more information about the programs available to you.

What is a Health Saving Account (HSA)?

Administered by Alerus

An HSA is a special type of tax-advantaged savings account which can be used to pay for future eligible health care expenses. It has no "use or lose" provision, meaning you can carry over the balance year after year, even after you have left St. Thomas.

An HSA provides triple tax advantage:

- You contribute via payroll on a pre-tax basis.
- Your balance can continue to grow year after year tax-free.
- Withdrawals to pay for eligible health care expenses are not taxed.

If you elect either **Plan 2** or **Plan 3**, you may also elect to open and contribute to a Health Savings Account Plan (HSA). You are eligible if you are not covered under another high deductible health plan, are not enrolled in Medicare and cannot be claimed as a dependent on someone else's tax return.

- IRS Contribution limits for 2023: Individual Coverage: **$3,850**/ Family Coverage **$7,750**.
- Those 55 years of age and high can fund an additional $1,000/year "catch-up" contribution.

University of St. Thomas Annual HSA contributions

	Plan 2	Plan 3
Employee-Only	$500	$750
Employee + Spouse	$600	$850
Employee + Child(ren)	$600	$850
Family	$1,000	$1,250

Opening an HSA

If you are contributing to an HSA for the first time through St. Thomas, you will need to open an account with Alerus, the custodian of the St. Thomas HSA program. In accordance with the US Patriot Act, Alerus will verify additional information and contact you as needed. For example, if you provided a P.O. Box address to St. Thomas for your mailing address, Alerus will ask you to provide a street address. If Alerus contacts you, respond as soon as possible. You will not be able to access your HSA balance until this verification process is complete

Once you are enrolled, sign up to access your account online at alerusrb.com. For more information on HSA accounts and Alerus, please visit **OneStThomas.**

Flexible Spending Accounts

Administered by HR Simplified

Below are the two different flexible spending accounts you may choose from. Note that, per the IRS, if you elect to contribute to an HSA, you cannot also have an FSA. You must elect the plans and contributions for 2023.

Medical Flexible Spending Account

- Available to those enrolled in Plan 1. Those enrolled in Plan 2 or 3 who have opened an HSA account are not eligible.
- Deduct money pre-tax to pay for eligible medical expenses not covered by the medical plan such as deductible, coinsurance, prescription drug copays, dental and vision expenses
- **$3,050** maximum contribution
- Use it or lose it
- You may carryover up to **$610** of your remaining contribution for reimbursement of services in the following year

Dependent Care Flexible Spending Account

- Available to any eligible employee working 26 hours or more a week, available for Plan 1, 2 and 3.
- Deduct money pre-tax to pay for dependent care expenses
- $5,000 maximum contribution
- Use it or lose it
- You have a grace period for dependent care which allows for additional time to spend down your dependent care contributions from one year until March 15th of the following year

Want to learn more about Flexible Spending Accounts? Click **here**.

PLANselect Plan Comparison Tool

PLANselect will help you select the best health plan to meet the unique needs of you and your family,

Results are based on credible, normative data from over 195 million claims, advanced statistical analysis, and decades of medical and health insurance expertise. Our model incorporates what we've learned from helping thousands of employers, employees and individuals make value-based decisions

in selecting a health plan, just like the analysis one would do in making any major purchase, like a car or home.

Using PLANselect is Easy!

1 **Log Into the University of St. Thomas Site**
Visit: www.myplanselect.com

Username: stthomas
Password: university

2 **Answer Four Questions**
After accepting the user agreement, the model will walk you through four simple, multiple-choice questions about your medical needs. You can finish in a couple minutes, no research required.

3 **Review Analysis and Recommendation**
PLANselect provides a financial analysis that ranks the plans based on finding the highest value and providing the services you need for the lowest total cost.

How It Works...

PLANselect results are based on credible, normative data from over 195 million claims, advanced statistical analysis and decades of medical and health insurance expertise.

Our decision-support tool incorporates lessons from helping thousands of employers, employees and individuals make value-based decisions in selecting a health plan, just like the analysis one would do in making any major purchase, like a car or home.

4 **Enroll**
You can run multiple scenarios with PLANselect if you'd like. **Once you make a decision, return to your enrollment system to make your selection.**

To access the 2023 PLANselect tool and learn more about how the PLANselect tool can help you make the best health plan decision for you and your family click **here**.

Dental Coverage

Administered by Delta Dental of Minnesota

The St. Thomas dental plan is self-insured and if elected, you pay toward the cost of this coverage. Your coverage utilizes the two Delta Dental networks of providers. The Delta Dental PPO network and the Delta Dental Premier network. You are encouraged to use the Delta Dental PPO network because there is no deductible, and it provides a deeper discount for services provided.

Summary of Dental Benefits

There is a deductible and annual benefit maximum as noted in the chart below. The deductible is waived for diagnostic and preventive care, orthodontic services if using a Delta Dental PPO dentist.

	Delta Dental PPO (In-Network)	**Delta Premier** (In-Network)
Deductible *(Calendar Year)*	None	$25 Individual $75 Family
Annual Benefit Maximum	$1,500 Per Person	$1,500 Per Person
Diagnostic & Preventive	100%	100%
Basic Services	100%	10% After Deductible
Periodontics	20%	20% After Deductible
Endodontics	20%	20% After Deductible
Oral Surgery	20%	20% After Deductible
Major Services	50%	50% After Deductible
Orthodontics *(Children Ages 8-18 yrs)*	50% up to $1,500 Max. Per Lifetime	50% up to $1,500 Max. Per Lifetime

Employee Bi-weekly premium	
Employee	$12.83
Employee + spouse	$32.11
Employee + child(ren)	$29.44
Family	$46.39

**Payroll is bi-weekly (26 pay periods), but benefit deductions are taken on the first two pay periods of each month (24 pay periods).*

Vision Coverage

Administered by EyeMed

Please see below for a highlight of benefits.

	In-Network (Member Cost)	**Out-of-Network** (Reimbursement)
Exam **Retinal Imaging**	$10 Copay $10 Copay	Up to $30 Up to $15
Contact Lens Fitting & Follow-up Standard Contacts Premium Contacts	Up to $55 10% Off Retail	n/a n/a
Frames	No Copay; $170 Allowance 20% discount on charges above $170	Up to $65
Standard Plastic Lenses	Generally, $25; Progressive $90, 20% off retail there after	$25 - $60
Lens Options	Generally, $0; see annual enrollment website for more information	Up to $5
Contact Lenses	No Copay; $170 Allowance 20% discount on charges above $170	Up to $120
Frequency Examination, Lenses, Contacts and Frame	Once every 12 Months	Once every 12 Months

Employee Bi-weekly Premium	
Employee	$3.97
Family	$10.66

**Payroll is bi-weekly (26 pay periods), but benefit deductions are taken on the first two pay periods of each month (24 pay periods).*

Life and Accidental Death and Dismemberment (AD&D) Insurance

Administered by The Hartford

During the Open Enrollment Period:

- If you and/or your spouse are currently enrolled in Optional Life Insurance coverage, you may elect to increase life insurance coverage up to the guaranteed amounts ($200,000 for you or $50,000 for your spouse) without providing Evidence of Insurability (EOI).
- If you and/or your spouse are not currently enrolled and you wish to enroll, EOI will be required regardless of the coverage amounts elected.
- You may add or change optional AD&D coverage for you, your spouse and/or your children without EOI.

Options	Life and AD&D Coverage
Basic Life/AD&D	UST provides a policy that covers 2x your annual salary to a maximum $200,000 benefit. There is no cost to you for this coverage.
Optional Employee Coverage	You may purchase optional life insurance in increments of $10,000 up to the lesser of $500,000 or 5x your annual salary. EOI is required for amounts over $200,000 of coverage. Coverage reductions begin at age 70.
Optional Spouse Coverage	If you purchased coverage for yourself, you may purchase spouse coverage in increments of $10,000 up to the lesser of $500,000 or 100% of your employee election. EOI is required for amounts over $50,000.
Optional Dependent Coverage	If you purchased coverage for yourself, you may choose to purchase $5,000 or $10,000 in dependent life coverage.
If you are married to another benefit eligible St. Thomas employee, you may not elect spouse coverage on each other. Only one employee may elect dependent coverage for your children.	

To enroll or make changes: If you would like to enroll for the first time or make changes to your Life and Accidental Death and Dismemberment (AD&D) Insurance, contact the Human Resources office at HumanResources@StThomas.edu to request **The Hartford Benefits Coverage Information** form. Complete, sign and submit the form to the Benefits Office.

If Evidence of Insurability (EOI) is required as explained above, you will submit your EOI online as follows:

1. After your Optional Life Insurance enrollment information is submitted, The Hartford will send instructions to your St Thomas email address, providing you with the website and login/password instructions to complete the EOI process online.
2. If no email address was provided to The Hartford, you will be notified by paper via US postal service, on how to complete the EOI process.

You may submit EOI for yourself and your spouse at the same time. Pending receipt of approval from The Hartford, coverage will be capped at the level not requiring EOI ($200,000 for employee coverage or $50,000 for spouse coverage). Once approval is received, any additional approved coverage will be effective on the date indicated by The Hartford and your premiums will be adjusted accordingly.

Short Term and Long Term Disability

Short Term Disability Plan (STD)

If you become disabled, after a 7-day waiting period for illness or injury, the STD plan provides a weekly benefit equal to 100% of your base salary for 4 weeks (up to a maximum of 8 weeks maternity) 70% thereafter. St. Thomas provides you with this coverage at no cost to you.

Long Term Disability Plan (LTD)

The LTD plan provides a monthly benefit equal to 60% of your base salary up to $15,000 if you become disabled under the LTD Plan. St. Thomas provides you with this coverage at no cost to you. During the open enrollment period, you have the option to elect if you want to be taxed on the premiums paid by St. Thomas.

See the example below.

1 If UST pays the entire LTD premium, then the disability benefits received are 100% taxable to the employee.

2 If you choose to be taxed on the premium that UST pays (called a gross up), then the benefits received are not taxable.

Examples to consider

Two LTD Scenarios	$40,000 annual income after tax (30%) take home $28,000		$70,000 annual income after tax (30%) take home $49,000	
	Pre-tax contributions	Post-tax contributions	Pre-tax contributions	Post-tax contributions
LTD monthly premium	$4.20	$4.20	$7.35	$7.35
Increased annual salary due to gross up	n/a	$50.40	n/a	$88.20
Monthly tax on premium	n/a	$1.26	n/a	$2.21
Monthly LTD benefit when disabled	$2,000	$2,000	$3,500	$3,500
Monthly Tax on LTD benefit (30%)	$600	n/a	$1,050	n/a
Total LTD monthly payment	$1,400	$2,000	$2,450	$3,500
Income Replacement ratio	60%	86%	60%	86%

You may want to consult with your financial advisor before open enrollment. The majority of the time, most will recommend post-tax when it's available. This results in a tax free LTD payment accomplishing two things: lowering one's tax obligation when finances might be tight during a disability, and even though the benefit is paid at 60% of your base salary, considering the LTD payment is tax free gets you closer to pre-disability earnings.

Legal Benefit

This employee-paid benefit gives you access to legal advice from a nationwide network of more than 13,000 attorneys and/or receive representation on a range of legal matters including wills, real estate, elder law and more. See Met Law Brochure for a list of covered services.

If elected, you must participate in the program for the entire calendar year at a cost of $18.90 per month.

Hourly Employee Purchased Leave Time (HEPLT)

Regular hourly employees may purchase additional PLT equal to five days or 40 hours in a calendar year (pro-rated based on FTE if part-time) for a pro-rated reduction in their salary. Enrollment in this program requires manager approval.

If you are a regular hourly employee and are interested in purchasing HEPLT, review and complete the HEPLT Program and Form. The reverse side of the form explains the features of this program. Please contact HR for questions.

Transamerica Retirement Plan

Benefit eligible employees will receive a 9.4% employer contribution the first of the month following one year of service. You will be 100% vested after three years of service as long as you have accrued 1,000 eligible worked hours for each year.

stthomas.trsretire.com

First-Time Users

- Select "New User? Get started."
- Follow the instructions to establish a user name and password.

Frequent Users

- Sign in to your account by entering your username and password.
- Click on the name of the account you want to access.

With the **My TRSRetire app**, connecting with your retirement plan has never been easier.

- View your account balance and rate of return
- Know *Your Retirement Outlook*℠
- Model ways to improve your forecast
- Take action right from your device

It's that simple. Download the app from the App Store or Google play today!

Brighten Your Outlook®

Easy access to your account

Your plan website is the first step for anything you want to know about your account. Use it to sign in to your account, find information about your retirement plan benefits, and learn more about saving for your future.

Once you have signed in, you can review the current status of your account, make changes, and access tools to help you personalize your retirement strategy. From the main menu, scroll over the five tabs—**Home, Review, Manage, My Profile,** and **Resource Center**—and select the action you want to take from the drop-down lists.

Check Account Balance

- Balance automatically appears on the Overview page (in the Home menu at the top of the screen).
- For account balance by fund, click "Details."

Review Investment Performance

- To get performance and fee details for all the funds in your plan, in the Review menu, click "Fund and Fee Information."

Change Contribution Amount

- To choose or change your contribution amount and sign up for annual auto-increases, in the Manage menu, click "Contributions."

Change Future Investment Allocations (*new contributions*)

- To choose or change how new contributions will be invested, in the Manage menu, click "Future Allocations."

Transfer Between Investment Options (*current assets*)

- To transfer balances between individual or groups of funds, in the Manage menu, click "Transfers."
- To change your overall investment mix, in the Manage menu, click "Current Allocations."

Name or Change a Beneficiary

To name or change your beneficiary, in the Home menu, click "Beneficiaries."

Please note that if you are married and you wish to designate someone other than your spouse as a primary beneficiary, consent from your spouse may be required by your plan.

Customer Service

- To email us, click on the Help Menu. To call us, call 800-755-5801.

2023 Open Enrollment Checklist

WHAT YOU NEED TO DO

MURPHY Online will be available **October 31 – November 11, 2022** for benefit eligible employees to make their elections for the 2023 plan year. During this enrollment period, employees must elect or waive coverage for medical, dental, vision, Health Savings Account (HSA), and Flexible Spending Accounts (health care & dependent care).

Your current Long Term Disability taxation and MetLaw elections will stay the same for 2023 unless you make changes.

Life/AD&D Insurance elections will remain the same unless you submit a new **election form**. You can also review your current elections via **MURPHY Online.**

- Enroll or waive 2023 benefit elections:
  - ☐ Medical Plan – add or waive coverage
  - ☐ Dental – add or waive coverage
  - ☐ Vision – add or waive coverage

- Enroll, change, or waive 2023 benefit elections (no action is required there is no change to the following benefits:
  - ☐ LTD taxation – pre or post tax
  - ☐ MetLaw – add or cancel coverage

- Must enroll each plan year:
  - ☐ Contribute to a Health Savings Account (HSA)
  - ☐ Contribute to the Health Care Flexible Spending Account
  - ☐ Contribute to the Dependent Care Flexible Spending Account

- Enroll, change or cancel your election (paper form):
  - ☐ Optional life and AD&D insurance
  - ☐ Add/Drop Dependent Form (to make changes to your dependent coverage for 2023)

- Verify personal information for accuracy
  - ☐ Social Security Numbers for yourself and your enrolled dependents
  - ☐ Dates of birth for yourself and your enrolled dependents
  - ☐ Home Address
  - ☐ Beneficiary designations

- Submit proof of relationship to the Benefits Office within 30 days if enrolling a spouse or dependent for the first time.

After Open Enrollment, changes for most benefit plans are generally not allowed during the year unless you experience a "qualifying life" event.

For questions or assistance contact Human Resources at **humanresources@stthomas.edu** or 651-962-6510.

Carrier Contacts

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
Medical Insurance **Group# (See plan documents)**	United Healthcare	1-833-404-2190	www.whyuhc.com/ust
Dental Insurance **Group #004070**	Delta Dental	800-553-9536	deltadentalmn.org
Vision Benefits **Group #1002780-01**	EyeMed	866-939-3633	eyemedvisioncare.com
Flexible Spending Accounts	HR Simplified	888-318-7472	hrsimplified.com
Basic Life and AD&D Insurance, Voluntary Term Life Insurance, Disability Insurance **Group #61400/697448**	The Hartford	888-301-5615	abilityadvantage.thehartford.com
Health Savings Account	Alerus	877-661-4727	alerusrb.com

University of St. Thomas

Important Legal Notices

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

coverage is lost under Medicaid or a State CHIP program; or
you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse, and dependent children when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the employer.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, and any required notice of that event is properly provided to the employer, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless the Plan sponsor has chosen to subsidize the cost of COBRA continuation coverage

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

Your dependent children will be entitled to elect COBRA if they lose group health coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employees' hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice to: The Human Resources department at HumanResources@StThomas.edu 651-962-6520.

If these procedures are not followed or if the notice is not provided during the 60-day notice period, ALL QUALIFIED BENEFICIARIES LOSE THEIR RIGHT TO ELECT COBRA.

How is COBRA continuation coverage provided?

Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the

covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

This extension due to a second qualifying event is available only if you notify the employer in writing of the second qualifying event within 60 days of the date of the second qualifying event. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the individual health insurance carriers, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed,

after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[1] **https:// www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.**

Important Notice from United Healthcare About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with United Healthcare and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. United Healthcare has determined that the prescription drug coverage offered by University of St. Thomas is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current University of St. Thomas coverage will be affected. For those individuals who elect Part D coverage, coverage under the University of St. Thomas plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current United Healthcare coverage, be aware that you and your dependents will [or will not] be able to get this coverage back, depending on University of St. Thomas' eligibility policy. This may affect your medical coverage as well, so be sure to contact the human resource department at University of St. Thomas.

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

You should also know that if you drop or lose your current coverage with The University of St. Thomas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage… See the contact information below. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through United Healthcare changes. You also may request a copy of this notice at any time.

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

If you decide to join a Medicare drug plan, your current University of St. Thomas coverage will be affected. For those individuals who elect Part D coverage, coverage under the University of St. Thomas plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current United Healthcare coverage, be aware that you and your dependents will [or will not] be able to get this coverage back, depending on University of St. Thomas' eligibility policy. This may affect your medical coverage as well, so be sure to contact the human resource department at University of St. Thomas.

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

You should also know that if you drop or lose your current coverage with The University of St. Thomas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage… See the contact information below. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through United Healthcare changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage… More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov

• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,

• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2023

University of St. Thomas, Minnesota
2115 Summit Avenue
St. Paul, Minnesota 55105 USA

Human Resource Office

651-962-6510

HumanResources@StThomas.edu

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: Health Insurance Premium Payment (HIPP) Program **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid – Medicaid and CHIP (Hawki)**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+:**https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442	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
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: **https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268	Website: **https://www.kancare.ks.gov/** Phone: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**
INDIANA – Medicaid	**LOUISIANA – 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	Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	**NEVADA – Medicaid**
Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 800-977-6740 TTY: Main relay 711	Medicaid Website: **http://dhcfp.nv.gov/** Medicaid Phone: 1-800-992-0900
MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Website: **https://www.mass.gov/info-details/masshealth-premium-assistance-pa** Phone: 1-800-862-4840	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MINNESOTA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	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
MISSOURI – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MONTANA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
NEBRASKA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855 632-7633 Lincoln: 402 473-7000 Omaha: 402 595-1178	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip**

	Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075	Website: **http://greenmountaincare.org/** Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462	Website: **http://www.coverva.org/hipp/** **https://www.coverva.org/en/hipp** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	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, 2022**, or for more information on special enrollment rights, contact either:

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

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

Notes

University of St. Thomas
Aquinas Hall, Room 202 St. Paul Campus
2115 Summit Avenue
St. Paul, Minnesota 55105, USA