MILLIGAN
UNIVERSITY

2024

EMPLOYEE BENEFITS GUIDE

CBIZ

2024 BENEFITS OVERVIEW

FOR BENEFITS EFFECTIVE 6/1/24 - 5/31/25

The Milligan University annual insurance open enrollment period is about to begin.

SUMMARY OF 2024 CHANGES

- Our medical coverage remains through BCBST. The deductible of the HDHP plan has increased in order to remain compliant with IRS standards.
- The pharmacy administrator remains with Veracity/ ProCare RX.
- Members will have an ID card for Medical/Dental/Vision coverage (BCBST) and a separate ID card for Prescription Drug coverage (Veracity/ProCare RX).
- **Members will receive a new BCBST Medical/Dental/ Vision ID card if they are on the HDHP plan, changing plans, or electing coverage for the first time.**
- **ProCare Rx is adding a "PCN" to the ID card so EVERY MEMBER enrolled on either medical plan will be receiving a new ID card.**
- Guardian will be the carrier for Life, Disability and all worksite products.

HOW TO GET STARTED

We recognize this is a busy time as we wrap up another academic year, but please set aside time during open enrollment to review your current elections in Employee Navigator and elect or waive coverage for the new year. Open Enrollment this year is mandatory. **All benefit-eligible employees must log into Employee Navigator and elect or waive coverage.**

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the Milligan University community and look forward to a healthy and safe 2024.

TIP REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

MILLIGAN UNIVERSITY

Enroll online through Employee Navigator by

CLICKING HERE

See Pages 20-21 for Step-by-Step Instructions on setting up your Employee Navigator account and making benefit elections.

If you need assistance Contact the CBIZ Service Center at 844-200-2249

CBIZ

TABLE OF CONENTS

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

CBIZ

CBIZ Service Center
844-200-CBIZ (2249)
CBIZTNCS@CBIZ.com

Call Toll Free for assistance with:

- Benefit Plan Questions
- ID Cards
- Claims Issues and Resolution
- In-Network Provider Listings

CBIZ Benefits and Insurance Services

CONTACT INFORMATION

MEDICAL
BlueCross BlueShield of Tennessee
www.BCBST.com
1(800) 565-9140

PHARMACY
Veracity Rx — ProCare Rx
www.veracity-rx.com
https://memberaccess.procarerx.com
1(800) 699-3542

DENTAL
BlueCross BlueShield of Tennessee
www.BCBST.com
1(800) 565-9140

VISION
BlueCross BlueShield of Tennessee
www.BCBST.com
1(800) 565-9140

FLEXIBLE SPENDING ACCOUNTS
Pinnacle Bank
www.pnfp.com
1(800) 264-3613

HEALTH SAVINGS ACCOUNTS
Pinnacle Bank
www.pnfp.com
1(800) 264-3613

LIFE & AD&D, LONG-TERM DISABILITY. VOLUNTARY LIFE & AD&D, SHORT-TERM DISABILITY, CRITICAL ILLNESS & ACCIDENT INSURANCE
Guardian
www.guardianlife.com
1(888) 482-7342

YOUR BENEFITS ADMINISTRATOR
Leslie A.M. Bean
Human Resources Director
LABean@milligan.edu

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of Milligan University, you have the choice between two medical plan options: **Option 1, which is considered an HDHP or High Deductible Health Plan OR Option 2, which is a traditional Copay plan with a lower deductible.**

For each plan option, your deductible will run from January 1st-December 31st.

While both plans give you the option of using out-of-network providers, you can save money by using in-network providers because BlueCross BlueShield has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and BCBS UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

The high deductible plan (OPTION 1) offers you lower premiums than the copay plan (OPTION 2), and you can establish a Health Savings Account (HSA) with Pinnacle Bank and contribute all or part of the premium savings. These funds can be used to cover medical expenses, including deductibles, and they're yours forever — even if you leave Milligan University.

TIP Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? **Who is eligible for medical insurance?** All full-time employees working a minimum of 30 hours per week on a regular basis, as well as retirees who meet the following eligibility requirements: they have been on Milligan's health plan for 10 years prior, have worked at Milligan for at least 25 years, and are between the ages of 60-65 (before they would become eligible for Medicare coverage), are eligible for medical coverage.

? **Will I receive a new medical ID card?** If you are on the HDHP plan, changing plans, or enrolling in coverage for the first time you will receive a new medical ID card. ProCare Rx is adding a "PCN" to the ID card so EVERY MEMBER enrolled on either medical plan will be receiving a new ID card.

? **Can I have both an HSA and FSA?** No, the IRS does not allow an individual or tax dependent members of the same household to have access to both types of accounts.

? **How long can I cover my dependent children?** Dependent children are eligible until the end of the month in which they turn age 26.

Blue Cross Blue Shield of Tennessee

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- OPTION 1: **HDHP**
- OPTION 2: **COPAY**

FIND A PROVIDER

- Go to www.bcbst.com
- Click on "Find Care"
- Select the "Blue Network S" network & enter your zip code
- Enter a Name, Facility, or Specialty or use the Browse by Category feature

PLAN OPTION 1 - HDHP

OFFERS SEVERAL BENEFITS:

- Lower premium contributions
- Routine preventive exams and labs are covered at 100%
- Catastrophic coverage
- The HSA is owned by you
- You have more control over your health care dollars

PLAN OPTION 2 - COPAY

MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You are not interested in establishing a Health Savings Account
- You would rather pay more in monthly premiums and less on medical expenses when they occur
- You expect to incur medical expenses at the beginning of the year and don't have the resources to pay for them

MEDICAL INSURANCE

of Tennessee

PLAN OPTIONS AND COSTS

BCBST	Option 1 - HDHP	Option 2 - COPAY
	Employee Cost - Monthly	Employee Cost - Monthly
Employee Only Employee & Family Two Employee - Family	$143.25 $401.50 $316.25	$247.50 $671.00 $506.00
	In-Network - Network S	In-Network - Network S
Deductible (calendar year) Individual / Family	$3,200 / $6,400	$2,000 / $4,000
Coinsurance (Member Pays)	50%	50%
Out-of-Pocket Maximum Individual / Family *(includes deductible, coinsurance & copays)*	$3,675 / $7,350	$3,000 / $6,000
Office Visit Primary Care Physician / Specialist	50% after deductible	$25 / $45 copay
Preventive Care	Covered at 100%	Covered at 100%
Diagnostics Lab and X-ray Major Diagnostics *(MRI, CT, PET...)*	50% after deductible	No additional copay 50% after deductible
Urgent Care	50% after deductible	$45 copay
Emergency Room	50% after deductible	$250 copay
Outpatient Surgery	50% after deductible	50% after deductible
Inpatient Hospital Services	50% after deductible	50% after deductible
	Out-of-Network	Out-of-Network
Deductible Individual / Family	$6,400 / $12,800	$4,000 / $8,000
Member Coinsurance	50%	50%
Out-of-Pocket Maximum Individual / Family	$11,025 / $22,050	$9,000 / $18,000

Outside of Open Enrollment, your election can only be changed during the plan year if you experience a **Qualifying Life Event.** You must notify Human Resources within 30 days of the event. Qualifying Life Event examples include, birth, marriage, death, spouse's open enrollment, Medicare eligibility, dependent turning 26, etc.

Both plans are detailed in the BCBS 2024 Certificate of Coverage (COC). The list above is a brief summary only. For exact terms and conditions, please refer to your certificate.

MEDICAL INSURANCE RESOURCES of Tennessee

TELEHEALTH

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

Telehealth lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes, and the doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

Teladoc gives you access to board-certified doctors who can consult with you by phone or secure video to help treat most non-emergency medical conditions. Sign up through BlueAccess, or call **1-888-283-6691** to get started.

BLUE365 DEALS

Blue365 offers savings on nutrition programs, fitness accessories, and medical supplies and services like hearing aids and LASIK eye surgery. If you're a member, starting saving with Blue365 today.

HEALTHY MATERNITY

If you're expecting, our Healthy Maternity Management Program can provide you with support throughout your pregnancy. Moms-to-be who enroll in our program can receive these benefits:

- Confidential maternity health advice
- Personalized one-on-one support from a maternity nurse
- Helpful prenatal information and online pregnancy resources
- Help with benefits and how to get the most out of them
- After-hours access to our toll-free 24/7 Nurseline for general health related questions
- Details about your baby's immunizations

For more information about the program, visit www.bcbst.com/Healthy-Maternity

BLUEACCESS

Once you enroll, make sure to sign up for your secure BlueAccess member website. Go to www.bcbst.com to register. BlueAccess makes it easy for you to: Find an in-network provider, get an ID card, review your claims, and compare estimated costs for doctors and health care facilities and so much more.

Check out more online tools and discounts:

- My Benefits and Coverage
- My Claims and Balances
- Find a Provider
- Cost Comparison Tool
- My Health & Wellness
- Personal Health Assessment
- Gym Memberships
- Health Coaching
- Weight loss programs
- Health living tips and articles
- Chronic Condition Management
- 24/7 Nurseline

TIP ANSWERS 24/7 - Teladoc & Nurseline are available all day, every day.

TN Log into the BCBST mobile app using the username and password from your online account.

PRESCRIPTION DRUG

As most of you know, prescription drug costs are unpredictable and rapidly rising each year. Our goal is to keep our employees' best interests in mind by providing the best coverage at an affordable premium.

Our Pharmacy Benefit Manager is Veracity ProCare Rx. The information in this guide will be helpful to you as we navigate through this plan and work to maintain superior prescription coverage.

For this plan year, you will have a separate ID card for Medical coverage and Pharmacy coverage. **ProCare Rx is adding a "PCN" to the ID card so EVERY MEMBER enrolled on either medical plan will be receiving a new ID card.**

HOW TO CONNECT

You can reach ProCare Rx 24/7. They are always available to take your call, even on holidays.

CALL 800.699.3542

or log into
https://memberaccess.procarerx.com

- Locate a pharmacy
- Understand your pharmacy benefit
- Get prior authorization information
- Learn formulary status and preferred alternatives

VERACITYRx

	Option 1 - HDHP	Option 2 - COPAY
	30 Day Retail	30 Day Retail
Generic	50% after deductible	$15 copay
Preferred Brand	50% after deductible	$50 copay
Non-Preferred Brand	50% after deductible	$70 copay
Preventive Drugs	$10 / $35 / $60 copay	Same as copays listed above
90 Day Retail	**Included - 3x copay**	**Included - 3x copay**
90 Day Mail Order	**Not Available**	**Not Available**
Specialty (REQUIRED)	**$0 Copay** - Specialty drugs are available through Veracity **Pharmacist Concierge Services**. Complete the Member Enrollment Form at www.veracity-rx.com	
International Pharmacy (OPTIONAL)	**$0 Copay** - A1C - Insulins - Antiviral /HIV drugs are available through Veracity **Pharmacist Concierge Services**. Complete the Member Enrollment Form at www.veracity-rx.com	

Note: *Some drugs require a pre-authorization. Even if you have obtained a pre-authorization with the current plan, you may have to obtain an updated one for the new plan.*

PHARMACIST CONCIERGE SERVICES

VERACITY RX — A team of healthcare benefits experts that help you navigate specialty drug assistance and brand name drug savings. Their goal is to help YOU save money without sacrificing the quality of care you receive.

Step 1: Please check the list below of commonly prescribed specialty drugs.

Step 2: If you or a covered member of your household are on any of the drugs listed, please submit the Member Enrollment form found at www.veracity-rx.com

So, what happens next? Once you submit your information, VeracityRx Pharmacist Concierge Services will be in touch within 2-3 business days to discuss your particular case. *Please note that a Consent Form will be required to give our Pharmacist Concierge authority to communicate with a patient's doctor or a foundation on their behalf.*

COMMONLY PRESCRIBED SPECIALTY DRUG LIST*

Drug	Drug
Actemra	Kuvan
Acthar	Lenvima
Adempas	Mekinist
Afinitor	Olumiant
Amjevita	Opsumit
Aubagio	Orgovyx
Cabometyx	Otezla
Cosentyx	Promacta
Dupixent	Rebif
Enbrel	Rydapt
Envarsus XR	Stelara
Epidiolex	Strensiq
Firazyr	Tafinlar
Gilenya	Taltz
Haegarda	Tobi Podhaler
Ilaris	Tremfya
Imbruvica	Tyvaso
Ingrezza	Vumerity
Jynarque	Zelboraf
Kesimpta	Zenpep

**List is only a sample of the top international drugs and is subject to change without notice. Not a list of 100% of drugs where assistance is provided.*

PHARMACIST CONCIERGE SERVICES

VERACITYRx

Get certain medications at $0 (zero) cost by following these steps:

Step 1: Please check the list below of **commonly prescribed medications that can be sourced internationally** (from Canada).

Step 2: If you or a covered member of your household are on any of the drugs listed, please start by going to www.veracity-rx.com and completing the **"Member Enrollment Form".**

Step 3: **Be on the lookout for an email** from a VeracityRx Personal Importation Team member with next steps.

Step 4: Contact your healthcare provider to have a new prescription sent into our pharmacy partner.

Instructions will be included in email on how to send in a new prescription

COMMONLY PRESCRIBED PERSONAL IMPORTATION LIST*

Drug	Drug	Drug
Anoro Ellipta	Invokamet	Skyrizi
Apidra	Isentress	Spiriva Respimat
Apidra Solostar	Janumet	Tagrisso
Arnuity Ellipta	Janumet XR	Tivicay
Atripla	Januvia	Toujeo Solostar
Basaglar Kwikpen	Jardiance	Tradjenta
Biktarvy	Juluca	Trelegy Ellipta
Breo Ellipta	Omnaris	Trintellix
Cimzia	Orencia	Trulicity
Combivent Respimat	Ozempic	Victoza
Dulera	Prezcobix	Xarelto
Eliquis	Pulmozyne	Xeljanz
Entresto	Qvar	
Farxiga	Rexulti	
Fiasp	Rinvoq	
Flovent HFA	Silenor	

**List is only a sample of the top international drugs and is subject to change without notice.*
Not a list of 100% of drugs where assistance is provided.

PHARMACY FAQ'S

? Who is my Pharmacy Benefit Manager?

Veracity Rx powered by ProCare Rx

? Are there preferred or non-preferred pharmacies?

There are a few pharmacies that are considered *non-select.* They are CVS, Rite-Aid, Sam's Club, Target, Walgreen's. All other pharmacies, including Walmart as of 1/1/23 are considered select. We encourage grocery store chains, locally-owned neighborhood pharmacies and Costco as your lowest cost options.

? Where can I fill my prescription?

Virtually any pharmacy can fill your prescription(s). However, you will pay a higher copay on prescriptions if you go to a non-preferred pharmacy. As a reminder, if you request a brand drug when a generic is available, you will pay the difference in cost.

? Can I get a 90 day supply?

Yes, a 90-day supply is available at any pharmacy, but you will save money on your prescriptions if you use a select pharmacy. A 90-day supply is only available at a retail pharmacy as we do not offer mail order.

? What is considered a Specialty or International drug?

Our VeracityRx Specialty Pharmacy Services can help you obtain your specialty or international drugs at the lowest possible cost for you and the company. Go to: **www.veracity-rx.com** to get started!

? Where can I fill my Specialty or Personal Importation prescription?

Our VeracityRx Specialty Pharmacy Services can help you obtain your specialty or international drugs at the lowest possible cost for you and the company. Go to: **www.veracity-rx.com** to get started!

? Will I pay more for a brand name medication when a generic is available?

If you request a brand name drug when a generic of the same medication is available, you will be responsible for your copay as well as the difference in cost between the generic product and the brand name product. Please note that the copay will never be greater than the cost of the brand itself.

Example: Brand Cost: Symbicort 160mcg/4.5mcg (1 inhaler) = $425 *(cost is subject to change)*. Generic Cost: Budesonide/formoterol 160mcg/4.5mcg (1 inhaler) = $210 *(cost is subject to change)*

Member Responsibility: Total Cost for Brand Name: $35 copay + $215 (cost difference between brand and generic) = $250

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three).

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave Milligan and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 1 (800) 264-3613, or log on to www.pnfp.com to review your HSA balance.

AT www.pnfp.com YOU CAN:

- View account information and activity
- File claims and access forms
- Order replacement HSA cards

Pinnacle℠ FINANCIAL PARTNERS

Contribute up to $4,150 Single, or $8,300 Family

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot contribute to an HSA if enrolled in Medicare Part A and/or B or TRICARE.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2024 are $4,150 for Single and $8,300 for Family coverage. If you're age 55 or older, you are allowed to make an additional $1,000 catch-up contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

What Is A Health Savings Account?

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pretax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. You can rollover up to $640 of your unused funds to the following plan year.

Plan Year is June 1, 2024—May 31, 2025.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Pinnacle Bank. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

2024 Maximum Calendar Year Contributions

Health Care Flexible Spending Account	$3,200 max
FSA Rollover Amount	$640 max
Dependent Care Expense Account	$5,000 max

Click here for the full list of Healthcare FSA Eligible Expenses

What Is A Flexible Spending Account?

Pinnacle FINANCIAL PARTNERS

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 1 (800) 264-3613, or log on to www.pnfp.com to review your FSA balance.

AT www.pnfp.com YOU CAN:

- View account information and activity
- File claims
- Manage your profile
- Look up eligible expenses
- Access forms
- View messages and notifications
- Order replacement FSA cards

All Active employees of Milligan University are eligible to elect a Healthcare Flexible Spending Account, even if you are not enrolled in the University's health plan, However you cannot contribute to both an Healthcare FSA and HSA (it is an either/or selection).

DENTAL INSURANCE

BCBST IS THE DENTAL CARRIER FOR 2024

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize an in-network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding BCBST's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

What Is Dental Insurance?

FIND A DENTIST

To find a BCBST provider in your area, visit the website at www.bcbst.com

- Go to www.bcbst.com
- Click on "Find Care"
- Select "Dental" network & enter your zip code
- Select the category of provider you want to search
- You can apply additional filters to narrow your search or leave them blank for a complete directory.

of Tennessee

DENTAL INSURANCE PLAN OPTIONS AND COSTS

BCBST	Employee Cost - Monthly	
Employee	$37.19	$22.51
Employee & Spouse	$84.81	$51.32
Employee & Child(ren)	$71.41	$43.21
Employee & Family	$120.52	$72.92

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

	Option 1 Standard Plan	Option 2 Preventive Plan	
Deductible Individual / Family	$0	$50 / $150	Applied to Type B & C Services
Annual Maximum	$1,250 per person	$750 per person	Applied to Type A, B & C Services, (Option 1) Applied to Type B Services (Option 2)
	Carrier Pays		
Diagnostic/Preventive Services	100% (no deductible)	100% (no deductible)	■ Exams, X-rays ■ Cleanings, Fluoride ■ Sealants, Space Maintainers
Basic Services	80%	80%	■ Basic Restorative Services ■ Basic and Major Endodontics ■ Basic and Major Periodontics ■ Basic Oral Surgery
Major Services	50%	Not Covered	■ Major Restorative and Prosthodontics ■ Major Oral Surgery ■ Implants
Orthodontia services Child(ren)	Not Covered	Not Covered	

VISION INSURANCE

BCBST IS THE VISION CARRIER FOR 2024

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize an in-network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.bcbst.com.

What Is Vision Insurance?

FIND A PROVIDER

To find a BCBST provider in your area, visit the website at www.bcbst.com

- Click on "Find Care"
- Select "Vision" network and then enter your zip code
- Select the category of provider you want to search
- You can apply additional filters to narrow your search or leave them blank for a complete directory.

of Tennessee

VISION INSURANCE PLAN OPTIONS AND COSTS

BCBST	Employee Cost - Monthly	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$2.00 $4.00 $4.00 $6.00	
	In-Network	Out-of-Network Reimbursement
Examination Copay	$10 copay	Up to $35
Frequency of Service Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	 Every 12 months Every 12 months Every 24 months
Lenses Single Bifocal Trifocal Standard Progressive Lenses	 $25 copay $25 copay $25 copay Add on additional $65 copay	 Up to $30 Up to $45 Up to $60 $0 reimbursement
Frames	$0 copay; $100 allowance, 20% off balance over $100	Up to $50
Conventional Contacts *(allowance includes materials only)*	$0 copay; $100 allowance, 15% off balance over $100	Up to $80
Disposable Contacts	$0 copay; $100 allowance	Up to $80
Medically Necessary Contacts	$0 copay, paid-in-full	Up to $200

VOLUNTARY COVERAGE

PROTECT YOUR FINANCES

- ELECT CRITICAL ILLNESS COVERAGE
- ELECT SHORT-TERM DISABILITY COVERAGE
- ELECT ACCIDENT COVERAGE

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances.

While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered — from deductibles and copays to living expenses.

This Critical Illness insurance policy from Guardian can help with the treatment costs of a covered critical illnesses — such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) — giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

CRITICAL ILLNESS COVERAGE INCLUDES:

- Wellness Benefit - Per year benefit for completing certain routine wellness screenings.
- Critical Illness Benefit payable for certain covered conditions including but not limited to, Cancer, Stroke, Heart Attack and other vascular conditions, Organ Failure, Kidney Failure and more.
- Cancer Vaccine Benefit

Guardian®

CRITICAL ILLNESS FEATURES:

- Benefits are paid directly to you
- Coverage is available for you, your spouse, and dependent children
- You can take your coverage with you if you change jobs or retire
- Pre-Existing Condition Limitation: 3 month look back period, 12 month exclusion period

HOW CRITICAL ILLNESS COVERAGE WORKS

What is Critical Illness Insurance?

1	2	3	4	5
Critical Illness coverage is selected	You experience chest pains and numbness in your left arm	You visit the emergency room	A physician determines that you have suffered a heart attack	Guardian Critical Illness coverage pays you a benefit

What Is Disability Insurance?

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through Guardian on a voluntary basis. The plan benefit is not to exceed 60% of basic weekly earnings.

Benefits are payable on the 1st day of an accident and on the 8th day for sickness. Benefits can continue for up to 13 weeks.

The costs for Critical Illness, Short-Term Disability and Accident coverage will vary, based on the amount of coverage that you elect, along with your age. Please review your record in Employee Navigator for payroll deduction costs. An Evidence of Insurability Form may be required for enrollment. Pre-existing conditions may also apply.

VOLUNTARY COVERAGE

Guardian

ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room — and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in. In the event of a covered accident (non-work related), the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills — expenses major medical may not take care of.

GUARDIAN ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches, and casts

BENEFITS INCLUDE:

- Wellness Benefit - Per year benefit for completing certain routine wellness screenings.
- Transportation and Lodging Benefits
- Medical Appliance
- Family Care
- Coverage for certain serious conditions, such as coma and paralysis
- Rainy Day Fund
- Traumatic Brain Injury

FEATURES:

- Coverage is guarantee-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire

HOW ACCIDENT INSURANCE WORKS

1. You select Accident Insurance
2. You injure your leg in a covered accident and go to the hospital by ambulance
3. The ER doctor diagnoses a fracture and treats you
4. You hobble out of the hospital on crutches
5. Guardian pays your benefit

What Is Accident Insurance?

LIFE INSURANCE AND LONG-TERM DISABILITY

PROTECT YOUR FAMILY

- REVIEW YOUR BASIC LIFE AND AD&D COVERAGE
- ELECT VOLUNTARY LIFE FOR YOURSELF AND DEPENDENTS
- REVIEW YOUR LONG-TERM DISABILITY COVERAGE
- REVIEW YOUR LIFE + LONG TERM CARE COVERAGE

BASIC LIFE AND AD&D

Milligan University provides you with $25,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Guardian Life at no cost to you.

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D coverage beyond what Milligan University provides. Typically, the carrier guarantee issues coverage during your initial enrollment period only — which means you can't be turned down for coverage based on medical history.

Milligan is moving to Guardian for the Voluntary Life and AD&D coverage. **Moving to a new carrier Creates a true Open Enrollment opportunity, where members can elect up to the Guarantee Issue without answering medical questions.**

Voluntary Employee Life & AD&D: minimum $10,000 to a maximum of 7x your annual salary, or $500,000, in $10,000 increments. Guarantee issue up to $120,000 (under age 70).

Voluntary Dependent Life & AD&D for spouse: minimum $5,000, not to exceed 100% of the approved employee life benefit or $200,000, in $5,000 increments. Guarantee issue up to $30,000 (under age 70).

Voluntary Dependent Life & AD&D for children: minimum $5,000 up to $10,000 maximum. Guarantee issue up to $10,000.

You must be enrolled in voluntary life and/or AD&D coverage in order for your spouse, and/or eligible dependent children to enroll.

If you elect Voluntary Life for yourself and/or your dependents, Voluntary AD&D is an automatic election based on the voluntary life insurance amount.

Be sure your beneficiary information is up to date in Employee Navigator.

What Is Life and AD&D Insurance?

Guardian®

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance offered through Guardian Life is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $8,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

The benefits begin on the 91st day of a covered disability and are payable until your Social Security Normal Retirement Age (SSNRA) if you are disabled from your own occupation.

- Pre-Existing Condition Limitation: 3 month look back period, 12 month exclusion period

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than 1/4 of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

EMPLOYEE ASSISTANCE PROGRAM (EAP) - GUARDIAN

GuidanceResources®

Your Life. Your Work. Your Best.®

Your GuidanceResources® Program

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Services:

Confidential Emotional Support
- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support
- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance
- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources
- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support
- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

Online Will Preparation
- Quickly and easily complete a will on your computer with EstateGuidance®
- Specify guardians, trustees and property division
- Provide funeral and burial instructions

Wellness Support
- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

Life is challenging. We can help.
Confidential 24/7 support.

ComPsych GuidanceResources® Worldwide | Guardian

24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: Guardian

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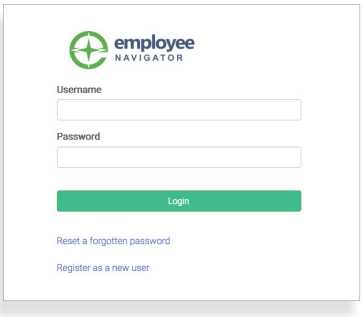
EMPLOYEE NAVIGATOR INSTRUCTIONS

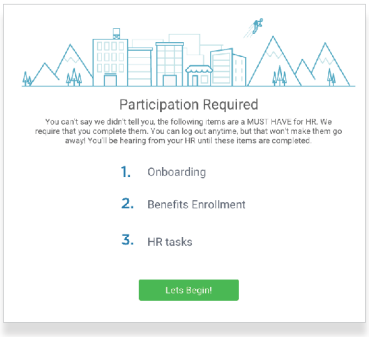


Step 1: Log In

Go to www.employeenavigator.com and click **Login**

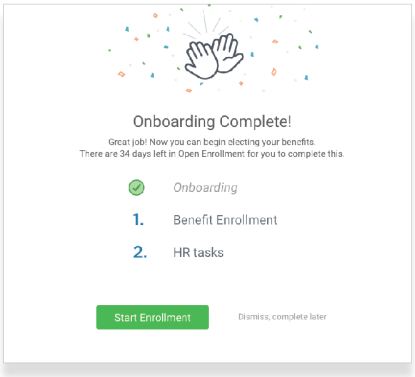
- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.

Company Identifier: MilliganEdu



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

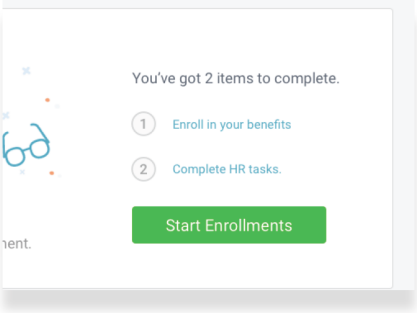


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

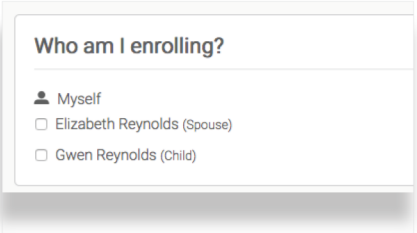
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

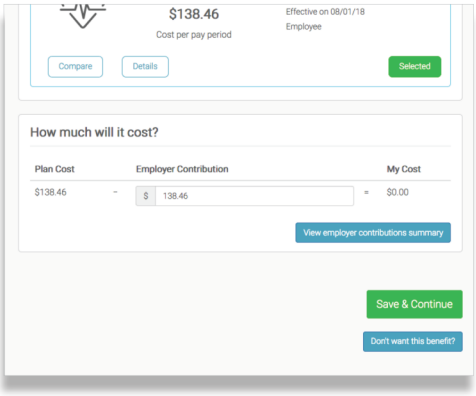
EMPLOYEE NAVIGATOR INSTRUCTIONS

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.



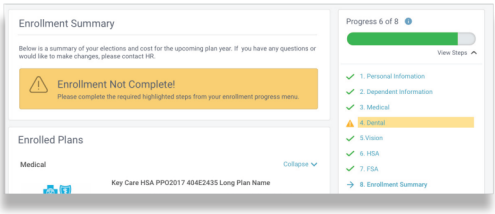


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

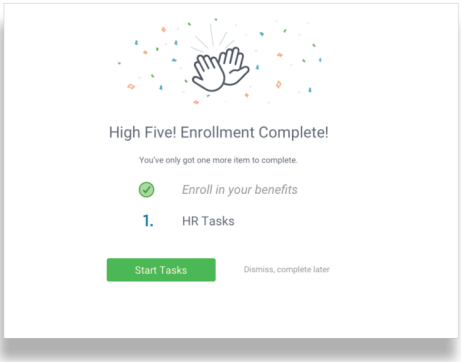


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

CBIZ

CARRIER LOGIN INSTRUCTIONS

of Tennessee

Follow these steps to sign up for your User ID and Password.

- Go to bcbst.com and click on “login/Register to Blue Access.”
- Click on the “Register Now” link and answer a few quick questions.
- You will need your BlueCross BlueShield of Tennessee member ID card.

The BlueCross BlueShield mobile app makes it easier than ever to get the plan information you need, when you need it. Log in using the username and password from your online account.

Guardian

Follow these steps to register your account.

- Go to guardianlife.com/login and choose “Member” as your User Role.
- Fill in your member information and Group ID Number(s) provided.
- Create a username and password, click “Submit” and you’re done.

Pinnacle FINANCIAL PARTNERS

Follow these steps to sign up for your User Name and Password.

- Go to www.pnfp.com or download the Pinnacle app.
- Under Online Banking, select “Sign In to Other Systems” and choose “Health & Benefits.”
- Click “Create your new username and password” under “New User.”
- Enter requested information and hit “next.”
    - Make sure you are using your legal name and your zip code is correct.
- Please select username and password.
- Set up security questions. If you have an HSA, you will be prompted to accept Terms & Conditions. This will only need to be done once. The next time you will log in as an Existing User.

Save time and gain the insight you need to manage your account by downloading the secure mobile app.

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Milligan University 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 Milligan University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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. 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. Milligan University has determined that the prescription drug coverage offered by the ProCare RX plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable 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 your current creditable prescription drug coverage, through no fault of your own, you will also 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 Milligan University coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will be eligible to receive all of your current health and prescription drug benefits.

Your current drug plan with Milligan University is as follows:

Option 1 RX: 50% coverage after deductible is met. Preventive Drugs: Tier 1: $10 copay
Option 2 RX: Tier 1: $15 copay, Tier 2: $50 copay, Tier 3: $70 copay.

You may retain your existing coverage and choose not to enroll in Part D plan; or you may enroll in a Part D plan in lieu of your other coverage.

If you do decide to join a Medicare drug plan and drop the Milligan University medical plan, **be aware that you and your dependents may not be able to get this coverage back** except in limited cases (such as a special enrollment event or open enrollment).

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 Milligan University 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 creditable 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…

Contact the person listed below for further information. **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 Milligan University 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	June 1, 2024
Name of Entity/Sender:	Milligan University
Contact--Position/Office:	Leslie A.M. Bean - Human Resources Director
Address:	PO Box 750, Milligan, TN 37682
Phone Number:	423-461-8712

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular copays, deductibles and co-insurance. Contact BCBST at the phone number on the back of your ID card for additional benefit information.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length 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 form the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF PRIVACY PRACTICES

Milligan University is subject to the HIPAA privacy rules, In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C before the IRS deadline. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

You'll need 1095 form to complete your Federal tax return.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.

Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if require to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator the provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Milligan University — ATTN: Leslie Bean
P.O. Box 750
Milligan, TN 37682
423-461-8712

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

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

IMPORTANT NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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/
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

IMPORTANT NOTICES

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

USERRA UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was signed on October 13, 1994. The Act applies to persons who perform duty, voluntarily or involuntarily, in the "uniformed services," which include the Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service commissioned corps, as well as the reserve components of each of these services. Federal training or service in the Army National Guard and Air national Guard also gives rise to rights under USERRA. In addition, under the Public Health Security and Bioterrorism Response Act of 2002, certain disaster response work (and authorized training for such work) is considered "service in the uniformed services" as well.

Uniformed service includes active duty, active duty for training, inactive duty training (such as drills), initial active duty training, and funeral honors duty performed by National Guard and reserve members, as well as the period for which a person is absent from a position of employment for the purpose of an examination to determine fitness to perform any such duty. USERRA covers nearly all employees, including part-time and probationary employees. USERRA applies to virtually all U.S. employers, regardless of size.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at www.dol.gov/vets.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
- The rights listed here may vary depending on the circumstances. The USRRA notice can be viewed on the internet at https://www.dol.gov/vets/programs/userra/USERRA_Private.pdf
- 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 for up to 24 months while in the military.
- Even if you don't 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 (e.g. ore-existing condition exclusions) except for service-connected illnesses or injuries.
- Under the terms of USERRA, if the military leave is 31 or fewer days, the employer may not charge a higher premium than would be charged to active employees with similar coverage. If the leave exceeds 31 days, the employer may charge up to 102 percent of the applicable premium.

Health Insurance Marketplace Coverage Options and Your Health Coverage *[for new hires only]*

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**.

Marketplace-eligible individuals who live in states served by **HealthCare.gov** and either- submit a new application or update an existing application on **HealthCare.gov** between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment -based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact: **Leslie Bean** at **LABean@Milligan.edu**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Milligan University	4. Employer Identification Number (EIN): 62-0535755	
5. Employer address PO Box 750	6. Employer Phone Number: 423-461-8712	
7. City: Milligan	8. State: TN	9. ZIP Code: 37862
10. Who can we contact about employee health coverage at this job? Leslie A.M. Bean - Human Resources Director		
11. Phone number (if different from above):	12. Email address: LABean@Milligan.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑ Eligible employees are: Full-time employees, working a minimum of 30 hours per week on a regular basis.

  ❑ Some employees.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: legal spouse, child(ren) up to age 26, and any dependent child(ren) who are totally disabled.

  ❑ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Above is the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

GLOSSARY OF MEDICAL TERMS

Coinsurance — The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays — A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible — The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room — Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum — All plans are required to have an unlimited lifetime maximum.

Medically Necessary — Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider — A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-Of-Pocket Maximum — The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization — A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs — Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services — All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

UCR (Usual, Customary and Reasonable) — The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care — Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

NOTES

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The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.