TUSCULUM
UNIVERSITY

2021 BENEFITS OVERVIEW

WHAT'S INSIDE

This guide is designed to provide a general overview of your benefits at Tusculum University. It is not a contract or an official interpretation of the benefit plans. For more detailed information, please refer to your summary plan descriptions or the legal plan documents.

Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. Tusculum reserves the right to modify or discontinue the plans at any time. This document was prepared exclusively for full-time employees of Tusculum. Unauthorized reproduction is strictly prohibited.

Benefits for new hires become effective on the first day of the month following 30 days consecutive service. If you have any questions, please contact Human Resources.

ENROLLMENT CHANGES

Changes to your enrollment may be made annually during open enrollment each year, or when certain qualifying events occur; including, but not limited to marriage/divorce; birth/adoption; death; change in job status for yourself or your spouse; change in Medicaid or CHIP eligibility.

However, all changes must be made within 30 days of your qualifying event (with exception of Medicaid/CHIP, which is within 60 days), or you will have to wait until the next open enrollment. You must notify Human Resources immediately when you experience a qualifying event.

SECTION 125 PLAN PREMIUM CONVERSION

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental, Vision, Flexible Spending Account, and retirement premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

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HOW TO ENROLL IN BENEFITS

1. Log in to:

   https://employeenavigator.com/benefits/Account/Login

2. Enter your Username and Password, and log in.
   - If you have not set up a username/password, select REGISTER A NEW USER. Your Company Identifier is **Tusculum**.
3. Follow the on-screen instructions to update your personal information, elect benefits, and complete any required tasks.
4. To submit your elections, select CLICK TO SIGN.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices for more details.

Tusculum University

MEDICAL BENEFITS

BlueCross BlueShield of TN | 1-800-565-9140 | www.bcbst.com | Group Number: 120156

Tusculum University has selected BlueCross BlueShield of Tennessee as its medical insurance provider.

SEMI-MONTHLY PREMIUMS	Option 1 *Buy-Up Plan*	Option 2 *Core Plan*	Option 3 *HDHP*
	Non-Tobacco		
Employee Only	$103.40	$62.18	$47.97
Employee + Family	$321.84	$216.95	$108.15
	Tobacco		
Employee Only	$154.02	$112.81	$100.17
Employee + Family	$387.65	$282.77	$177.36

To better suit the needs of all employees, Tusculum offers three options for medical insurance. All plan options utilize Network S. The Core Plan has a $1,250 individual/$2,500 family in-network deductible and a $35 office visit co-pay. Most other charges are paid at 70%, in-network. The Buy-Up Plan carries a $750 individual/$1,500 family in-network deductible and a $25 office visit co-pay. Most additional charges are paid at 80%, in-network. The HDHP has a $6,550 individual/$13,100 family in-network deductible. Once reaching the annual deductible/out-of-pocket maximum, all other charges are paid 100%.

All plans use the Preferred Provider Organization (PPO). To receive the maximum benefit from your PPO Plan, make sure your provider is a member of the Blue Network S. Under the PPO program, you have the flexibility to go to any provider that you choose and you are not required to choose a Primary Care Physician (PCP). However, anytime you select an in-network physician or facility, you will see significant discounts and savings. In-network providers will also file your claims for you. Network S is an extensive network within the BCBST system. Effective March 1, 2016, UT Medical Center and affiliated Physicians no longer participates in Network S.

Money Saving Tip

Use Teladoc when treating minor illnesses rather than urgent care or the emergency room, except in true emergency situations.

To find an in-network provider near you, go to www.bcbst.com and click on “Find a Doctor.” Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network.

If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. You are also responsible for the difference between billed charges and the maximum allowable charge. It definitely works to your advantage to use the in-network providers whenever possible.

MEDICAL BENEFITS	OPTION 1 BUY-UP PLAN	OPTION 2 CORE PLAN	OPTION 3 HDHP
	Network S In-Network	Network S In-Network	Network S In-Network
Calendar Year Deductible (Individual/Family)	$750 / $1,500	$1,250 / $2,500	$6,550 / $13,100
Out-of-Pocket Maximum (Individual/Family)	$3,500 / $7,000	$4,000 / $8,000	$6,550 / $13,100
Lifetime Maximum Benefit	Unlimited		
SERVICES RECEIVED AT A PRACTITIONER'S OFFICE AND PREVENTIVE SERVICES			
Office Visit//Wellcare Services age 6 and up*	$25 Co-pay	$35 Co-pay	100% after deductible
In-Office Lab and X-Ray	No Additional Co-pay	No Additional Co-pay	100% after deductible
Annual Well-Woman Exam	100%	100%	100% after deductible
Annual Mammography Screening, Cervical Cancer Screening, Prostate Cancer Screening	100%	100%	100% after deductible
Screening Flexible Sigmoidoscopy and Screening Colonoscopy	100%	100%	100% after deductible
Non-Routine Diagnostic Services	80% after deductible	70% after deductible	100% after deductible
SERVICES RECEIVED AT A FACILITY			
Inpatient Services*	80% after deductible	70% after deductible	100% after deductible
Outpatient Surgery (includes non-screening sigmoidoscopy and colonoscopy)*	80% after deductible	70% after deductible	100% after deductible
Routine Diagnostic Services-Outpatient	100%, no deductible	100%, no deductible	100% after deductible
Non-Routine Diagnostic Services-Outpatient	80% after deductible	70% after deductible	100% after deductible
Skilled Nursing Facility and Rehab Facility* (limited to 100 days per year)	80% after deductible	70% after deductible	100% after deductible
BENEFITS FOR OTHER COVERED SERVICES			
Durable Medical Equipment, Prosthetics and Orthotic Appliances	80% after deductible	70% after deductible	100% after deductible
Home Health Services* (limited to 100 visits per year)	80% after deductible	70% after deductible	100% after deductible
Ambulance Services	80% after deductible	70% after deductible	
THERAPEUTIC SERVICES			
Physical/Speech/Occupational (limited to 60 visits per type per year)	80% after deductible	70% after deductible	100% after deductible
Cardiac/Pulmonary Rehab (limited to 60 visits per year)	80% after deductible	70% after deductible	100% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Inpatient Services*	80% after deductible	70% after deductible	100% after deductible
Outpatient Services	$25 Co-pay	$35 Co-pay	100% after deductible
PHARMACY			
Generic/Preferred Brand Name/Non-Preferred Brand Name	$10/$25/$50	$10/$35 after brand-only deductible/ $60 after brand-only deductible	$5 / $25 / $50 Preventive Drugs Only
Brand Name Deductible	None	$200	
Specialty Pharmacy	30% Co-pay	30% Co-pay	
Step Therapy**	Included	Included	
Out-of-Pocket Maximum	$2,850	$2,350	

Chart reflects in-network benefits. For out-of-network benefits, please see your Evidence of Coverage.
* Prior authorization required (some outpatient procedures require prior authorization)
** Step Therapy is a form of prior authorization. When step therapy is required, you must initially try a drug that has been proven effective for most people with your condition. This initial drug will be a covered generic drug (if available) or a preferred brand drug. However, if you have already tried an alternate, less expensive drug and it did not work, or if your doctor believes that you must take the more expensive drug because of your medical condition, your doctor can contact the plan to request an exception. If the request is approved, the plan will cover the requested drug.

TELADOC

Teladoc | 1-800-835-2362 | www.teladoc.com

Tusculum is proud to offer Teladoc. Teladoc is available to Full and Part-Time Administrative Staff and Faculty (inluding Adjuncts). Teladoc is a national network of board certified physicians providing telephonic consultations 24/7 when your primary care physician is not available.

SEMI-MONTHLY PREMIUMS	
Employees Enrolled in Any Tusculum Medical Plan	Free
Employees Not Enrolled in a Tusculum Medical Plan	$2.20

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

You can talk with a Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app. To request a consult, visit the Teladoc website, log into your account and click “Request a Consult”. You can also call Teladoc to request a consult by phone, or request a consult through the Teladoc mobile app. A doctor will call you back in 16 min, on average.

Prescriptions. Teladoc doctors can prescribe short term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, nontherapeutic and/or certain other drugs which may be harmful because of their potential abuse. When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.

Please note: Teladoc is a *free* call-in service for general medical/health issues. *Dermatology services* have a *$75 copay.* It is always best to start your call requesting general practice as many conditions can be resolved without paying any copay.

You’ve got **Teladoc.** 24/7 access to doctors by phone or video.

1

Create account

Use your phone, the app or our website to create an account and quickly complete your medical history.

2

Request a visit

Use your device to request a visit and a Teladoc doctor will contact you at the requested time.

3

Feel better

Your doctor will diagnose your symptoms and even prescribe medicine, if needed.

VOLUNTARY DENTAL BENEFITS

BlueCross BlueShield of TN | 1-800-565-9140 | www.bcbst.com | Group Number: 120156

SEMI-MONTHLY PREMIUMS	
Employee Only	$14.60
Employee + Spouse	$32.12
Employee + Child(ren)	$26.43
Employee + Family	$47.89

Your dental benefits at Tusculum University are provided by BlueCross BlueShield of Tennessee (BCBST). If you choose a provider in the BCBST Network, you will see significant savings and discounts, as BCBST has agreements with these providers to not charge above a certain rate for services. Additionally, the provider's office will file a claim for you so there is no paperwork for you to fill out. To find an in-network dentist near you, go to the BCBST dental website, www.bcbst.com, and click on "Find a Doctor," then select Dental. Please be sure to consult either the online directory or BCBST's customer service to confirm that your dentist is in the network.

If you choose a provider not in the network, your charges will be subject to a maximum allowable charge which may result in balance billing. Dental benefits are divided into three coverages. 1) Preventive includes services such as exams, x-rays, cleanings, fluoride treatments (under age 19), sealants (under age 16) and space maintainers (under age 14). 2) Basic includes basic restorative procedures, basic oral surgery and basic periodontics. 3) Major includes major restorative services and prosthodontics, basic and major endodontics, major periodontics, major oral surgery and implants.

DENTAL BENEFITS	In-Network	Out-of-Network
Benefit Year Deductible *Applies to Basic and Major Only* Individual / Family	$25 / $50	$25 / $50
Calendar Year Maximum	$1,500	$1,500
1) Preventive	100%	100%
2) Basic	80%	80%
3) Major	50%	50%

*Should you choose to seek care from an in-network provider, you will receive higher reimbursement percentages.

VOLUNTARY VISION BENEFITS

Guardian | 1-888-600-1600 | www.guardiananytime.com | Group Number: 00498351

As an employee at Tusculum University, you have the option to enroll in a voluntary vision plan provided by Guardian. When using in-network Davis Vision providers, this PPO plan covers most exams, eyeglass and medically necessary contacts in full. To find an in-network provider or surgery center, call customer service or go to www.guardiananytime.com and click on "Find a Provider," select the Davis Vision plan, enter all desired information and click search.

SEMI-MONTHLY PREMIUMS	
Employee Only	$4.30
Employee + Spouse	$7.07
Employee + Child(ren)	$7.21
Employee + Family	$11.67

Should you choose to see an out-of-network provider, Guardian will reimburse you up to a specified amount. Please see the chart below for the out-of-network reimbursement schedule.

VISION BENEFITS	In-Network	Out-of-Network
Co-pays - Materials	$20	
Exams (once a year)	$20 Co-pay	$50 max (after Co-pay)
Standard Frames (once every 24 months)	$150 retail max + 20% off balance	$48 max (after Co-pay)
Standard Lenses (once a year; Single, Bifocal, Trifocal, Lenticular)	$20 Co-pay, 100%	Up to $126 max (after Co-pay), depending on type
Contact Lenses (once a year) *Medically Necessary* *Elective Allowance*	Covered after Co-pay $150 max (Co-pay waived)	$210 max $105 max (Co-pay waived)

FLEXIBLE SPENDING ACCOUNT

Benefits Assist | Shawn Adams | 1-865-769-2800 | 1-888-588-3650, Fax
Flex@BenefitsAssist.net | www.benefitsassist.net

Tusculum University offers its full-time employees the option to defer money on a pre-tax basis for use on approved medical expenses up to $2,750 per year. This is NOT insurance. This is simply a way for you to save on your medical expenses by setting money aside from your gross income, pre-tax, for expenses that you anticipate for the plan year. Employees are eligible for this benefit on the first of the month following 30 days of active service.

For the FSA, the total amount set aside for the plan year is eligible for withdrawal from the account on day one of your first payroll deduction towards the account. However, funds not used during the plan year will not roll over to the following year. Expenses must be incurred by December 31, 2021. All funds set aside for this account must be used towards your eligible medical expenses. The minimum FSA annual contribution amount is $200 and the maximum is $2,750.

Please note that as of January 1, 2011, most over-the-counter (OTC) drugs are not eligible for reimbursement under your FSA without an accompanying doctor's prescription. This includes items such as: cough, cold and flu remedies, pain relief, stomach remedies, sleep aids and sedatives, allergy and sinus medicines, and acid controllers. First aid supplies, contact lens supplies and solutions, insulin and diabetic supplies, and wheelchairs, walkers and canes are still eligible.

Contact Benefits Assist for a list of eligible medical expenses.

Pre-Tax Savings Example

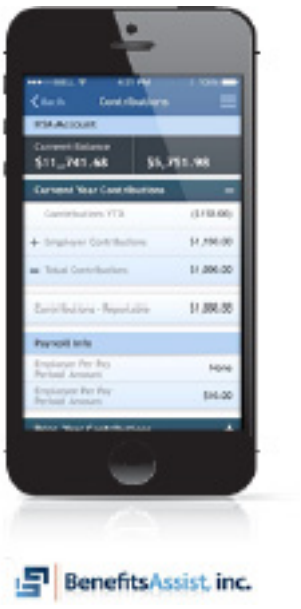
	Without FSA	With FSA
Gross Monthly Pay:	$3,500	$3,500
Pre-Tax Contributions		
Medical / Dental Premiums	$0	-$125
Medical Expenses	$0	-$75
Dependent Care Expenses	$0	$400
TOTAL:	$0	-$600
Taxable Monthly Income	**$3,500**	**$2,900**
Taxes (federal, state, FICA)	-$986	-$802
Out-of-Pocket Expenses	-$600	$0
Monthly Take-home Pay	**$1,932**	**$2,098**

Net Increase in Take-Home Pay = $166 / mo!

For illustration only. Actual dollar amounts may vary.

MOBILE ACCOUNT ACCESS

- Search for BenefitsAssist WealthCare on iTunes and Google Play
- Supports Apple and Android smartphones and tablets
- Shared username and password with web portal
- Health FSA, Dependent Care FSA, and HRA
- View account balances
- View transaction history
- Submit claims
- Attach receipts
- Contact administrator



EMPLOYEE ASSISTANCE PROGRAM

Guardian | 1-800-386-7055 | www.ibhworklife.com
Username: Matters | Password: wlm70101

Tusculum University is pleased to offer a 24/7 Employee Assistance Program (EAP) through Guardian. We encourage you to utilize this resource to help make your work and family life a little easier.

Guardian's WorkLifeMatters Employee Assistance Program is available at no cost to all Tusculum University employees and their families.

This Employee Assistance Program (EAP) provides for unlimited assistance by phone, as well as up to three face-to-face sessions with no charge. Guardian's advocates are trained to offer advice on a range of problems from coping with major life events to managing on-the-job issues. Your advocate can also direct you to an array of resources in your community as well as online tools. Should you need a legal consultation, you are eligible to receive free consultations plus discounts on legal services.

The program's website, www.ibhworklife.com, is a valuable tool with a host of resources. EAP helps with questions and concerns regarding dependent care and care giving, balancing work and home life, relocation, college planning, parenting support, anxiety and depression, marital issues, and more. More assistance programs can be found on the website or via the 24/7 hot line.

Education	Dependent Care & Care Giving	Legal & Financial	Working Smarter	Lifestyle & Fitness Management
• Admissions testing and procedures • Adult re-entry programs • College planning • Financial aid resources	• Adoption assistance • Before/after school programs • Day care and elder care • Parenting support • Senior housing options • Special needs care	• Basic tax planning • Credit and debt • Immigration • Legal forms and will making • Personal legal • Retirement planning	• Balancing work and home life • Career and training development • Effective managing • Relocation • Workspace diversity	• Anxiety and depression • Divorce and separation • Drugs and alcohol • Grief and loss • Health and well-being

BASIC LIFE & AD&D INSURANCE

Guardian | 1-800-541-7846 | www.guardianlife.com | Group Number: 00498351

Guardian's Group Life and Accidental Death and Dismemberment (AD&D) Insurance are provided to all full-time employees and paid for by Tusculum. The basic benefit provided is $20,000. Employees are eligible for this benefit on the first of the month following 30 days of active service.

With AD&D coverage, you are eligible to receive an additional benefit according to a schedule of losses such as loss of life, limb or sight due to an accident.

All Life and AD&D insurance amounts are subject to age reductions starting at age 65. Other restrictions apply. Please see your plan document for more details.

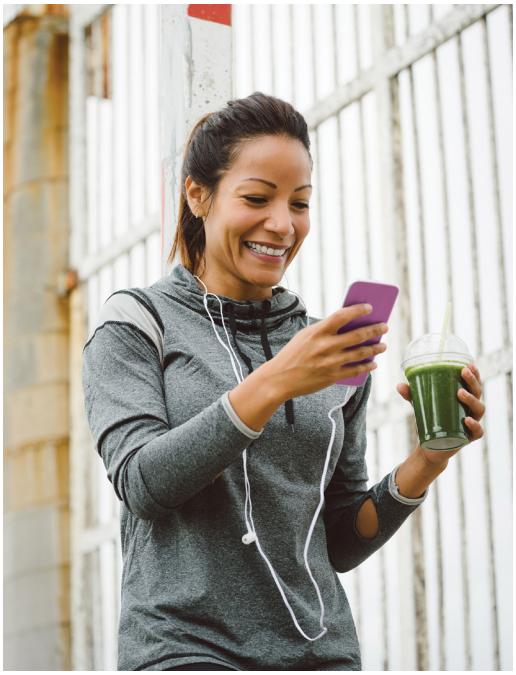
LONG-TERM DISABILITY INSURANCE

Guardian | 1-800-541-7846 | www.guardianlife.com | Group Number: 00498351

Long-Term Disability (LTD) Insurance is provided to all full-time employees and paid for by Tusculum University. LTD insurance can help protect your income in the event of a long-term disability or illness. Employees are eligible for this benefit on the first of the month following 30 days of active service.

If you are deemed disabled 180 days after an accident or onset of illness, you will be eligible to receive 60% of your monthly covered earnings, not to exceed $5,000 per month.

Please contact Human Resources immediately if you become injured or severely ill.



VOLUNTARY LIFE & DISABILITY PRODUCTS

Guardian | 1-888-600-1600 | www.guardiananytime.com

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

In addition to the company-paid Life and Accidental Death and Dismemberment (AD&D) policies, all active, full-time employees working at least 35 hours per week are eligible to purchase Voluntary Term Life and AD&D Insurance, provided by Guardian. These premiums are paid entirely by you on an after-tax basis. Tusculum will deduct the premiums from your paycheck. **Voluntary benefits must be selected upon your initial enrollment.**

You can select Voluntary Life and AD&D Insurance on yourself in units of $10,000 up to a maximum of five times your annual compensation, or $300,000, whichever is less. The **guaranteed issue*** amount for Voluntary Insurance on yourself is **$150,000**.

Voluntary Life and AD&D Insurance on your spouse can be purchased in units of $5,000 up to $150,000. The **guaranteed issue*** amount is **$30,000**. Life and AD&D Insurance on your child(ren) age 14 days to 26 years (26 if full time student) can be purchased for an amount of $10,000. All dependent child(ren) benefits are guaranteed issue*.

Guaranteed issue refers to the amount of insurance available that does not require evidence of good health.

All Life and AD&D Insurance amounts are subject to age reductions starting at age 65. Other restrictions may apply. Please see your plan document for more details.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is paid entirely by you.

You may select the benefit that is best for you. Different amounts and benefit durations are available.

VOLUNTARY AFLAC PRODUCTS

AFLAC | Heather Love - Aflac Benefits Coordinator | 1-865-924-0647
heather_love@us.aflac.com | www.aflac.com

Tusculum University provides access to voluntary benefits through AFLAC. The benefits are supplemental to your group insurance coverage and premiums are paid 100% by you. Tusculum University does not sponsor or endorse AFLAC products.

Injuries and illnesses not only result in out of pocket medical expenses (deductible, co-pays, etc.) but can also affect your ability to work resulting in a reduced or non-existent paycheck. Ask yourself, how long could you pay the bills (newly acquired medical expenses AND everyday living expenses such as mortgage, car payments, groceries, etc.) with a reduced or non-existent paycheck if YOU or a FAMILY MEMBER were sidelined due to an illness or injury? AFLAC helps bridge the financial gap which occurs when expenses increase and income decreases by paying cash directly to policyholders. Policyholders can use the money received from AFLAC at their discretion during their time of need. No one wants the added financial stress when trying to recover from an illness or injury.

Cancer: First Occurrence benefit starts at $4,000. Additional benefits include but are not limited to chemotherapy, radiation, hormonal therapy, anti-nausea medication, surgical/anesthesia, hospital confinement, transportation and lodging. The policy includes a $70 mammography benefit and a $75 cancer screening wellness benefit (per policyholder, per calendar year).

Specified Event: First Occurrence benefit of $5,000 paid upon the diagnosis of heart attack, stroke, sudden cardiac arrest, coma, paralysis, end-stage renal failure, persistent vegetative state, major organ transplant, major third-degree burns or coronary artery bypass surgery. Additional benefits include but are not limited to a re-occurrence benefit of $2,500; daily hospital confinement, continual care, ambulance, transportation, lodging and an intensive care daily confinement benefit.

Accident: 24/7 coverage for injuries on or off the job. Benefits include but are not limited to x-rays, diagnostic tests, hospital confinement, appliances (crutches/boot/etc.), fractures, dislocations, lacerations, surgeries, organized sporting activities, etc. The policy includes a $50k AD&D benefits as well as a $60 wellness screening benefit payable once per calendar year, per policy.

RETIREMENT PLAN

TIAA | 1-800-842-2733, Customer Service | www.tiaa.org
Plan Numbers:
Defined Contribution Retirement Annuity (RA): 337038
Supplemental Group Retirement Annuity (SGRA): 337039

Tusculum University is very pleased to offer a 403(b) retirement plan to all eligible employees. The 403(b) plan is provided through the Teachers Insurance and Annuity Association (TIAA). Tusculum offers two options, a Defined Contribution Retirement Annuity Plan (RA) and a Supplemental Group Retirement Annuity (SGRA). For more information, please contact Human Resources or TIAA.

PLAN FEATURES	DEFINED RETIREMENT CONTRIBUTION (RA)	SUPPLEMENTAL GROUP RETIREMENT ACCOUNT (SGRA)
Waiting Period	A full–time employee must have completed two (2) consecutive years of service at the institution prior to enrollment, and can enroll only on January 1 or July 1 following their anniversary date. An open 403(b) account with an eligible employer may be counted for meeting the eligibility requirements.	A full-time employee is eligible and may enroll anytime after the first of the month following 30 days of active service.
Employee Contribution	You can contribute 0–5% of your salary. The percentage can be changed at any time.	A percentage determined by you above 0% that can be changed at any time.
Allocation of Contributions	You may allocate plan contributions to the funding vehicles in any whole number percentages that equal 100%. You may change allocations of future contributions to the funding vehicles at any time by contacting TIAA.	
Defined Contribution	Tusculum may contribute a discretionary amount.	
Maximum Plan Contributions	Annual contributions made for any year cannot exceed the amount permitted under section 415 of the Code and Section 403(b).	
Vesting Schedule	Plan contributions shall be fully vested and non–forfeitable.	
Acceptance of Rollover Contributions	No rollovers accepted.	Contact TIAA for determination of eligible rollover contributions.

ADDITIONAL EMPLOYEE BENEFITS

Human Resources Team

Scott Smith, Chief Human Resources Officer | 1-423-636-7383 | scsmith@tusculum.edu

Lorrie Akers, Human Resources Generalist | 1-423-636-7345 | lakers@tusculum.edu

Lauren Duncan, Human Resources Assistant | 1-423-636-7426 | lduncan@tusculum.edu

TUITION REMISSION AND EXCHANGE

As added benefits for your service to Tusculum University, Tusculum offers Tuition Remission and Tuition Exchange programs for you and your family. To be eligible for tuition remission, the employee must be a full-time employee and have completed one year of consecutive, full-time service with the university.

The qualifying family member must produce proof of his or her immediate relationship with the university employee. The applicant must also meet all current admission requirements of the university program and have completed a FAFSA (Free Application for Federal Student Aid). Undergraduate and Graduate tuition remission is available for the employee; only the Bachelors degree tuition remission is available for the spouse and/or dependents. January 15th is the deadline to turn your tuition application in for the following academic year.

If you or your family members are accepted at another school in the Council of Independent Colleges (CIC) or the Association of Presbyterian Colleges and Universities (APCU), you may be eligible to receive tuition at no cost.

Please contact Financial Aid or Human Resources for more information.

Associate's, bachelor's or master's tuition remission is available for the employee. Associate's, first bachelor's degree, and master's tuition remission is available for the spouse. Associate's, first bachelor's degree, and dual enrollment tuition remission is available for eligible dependents. Tuition remission will cover 100% of tuition for eligible persons and programs for undergraduate courses. Tuition remission will cover 50% of tuition for eligible person for master's degree courses.

CAMPUS EVENTS

Tusculum is very proud of its extra-curricular programs and activities and invites all employees to take advantage of these campus events.

Tusculum encourages all of its employees and their families to take advantage of the extraordinary opportunities and programs on campus. Employees may get free admission to Pioneer sporting events, performances, and arts and lectures at the Annie Hogan Byrd Auditorium.

ANNUAL NOTICES

IMPORTANT NOTICES FROM OUR COMPANY REGARDING THE PLAN

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

Tusculum University
Contact: Human Resources Office
Mailing Address:
60 Shiloh Road
Greeneville, TN 37743
Phone: 423-636-7345
Distribution Date: November 2020

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her coverage and coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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). If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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.

If you would like more information on WHCRA benefits, contact your Health Insurance issuer.

MASTECTOMY NOTICE

Patients who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

In a manner determined in consultation with the attending physician and the patient. The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

Please contact Human Resources for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

NOTICE OF SPECIAL ENROLLMENT RIGHTS TO NEW ENROLLEES

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.

If you are decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's General Contact.

PLEASE REVIEW IT CAREFULLY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Our Company Health and Welfare Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective in April. [Note: the effective date may not be earlier than the date on which the privacy notice is printed or otherwise published].

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Our Company requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present

or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information. To the Plan Sponsor. We may disclose protected health information to certain employees of Our Company for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact: Human Resources.

PATIENT PROTECTION DISCLOSURE

Our Company generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact our medical provider, listed on the medical benefits page herein.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Our Company or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact our medical provider, listed on the medical benefits page herein.

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Produced and Printed by Trinity Benefit Advisors, 11/2020

Important Notice About Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan 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. **We have determined that the prescription drug coverage offered by the health 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 coverage [will or will not] be affected.

Prescription Drug Benefits	Option 1: Buy-Up Plan Network S	Option 2: Core Plan Network S	Option 3: HDHP Network S
Generic/Preferred Brand Name/Non-Preferred Brand Name	$10 / $25 / $50	$10 /$ 35 after brand-only deductible $60 after brand-only deductible	100% after deductible
Brand Name Deductible	None	$200	100% after deductible
Specialty Pharmacy	30% Copay	30% Copay	100% after deductible

Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/ options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents [may or may not] be able to get this coverage back.

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 health plan coverage 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 please contact the plan administrator indicated on the first page of this notice.

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 your current health plan provided by the current insurer 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:	1/1/2020
Name of Entity/Sender	Tusculum University
Contact -- Position / Office:	Human Resources Office
Address:	60 Shiloh Road Greeneville, TN 37743
Phone:	423-636-7345

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – 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: 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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY- Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – 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: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2020, 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.