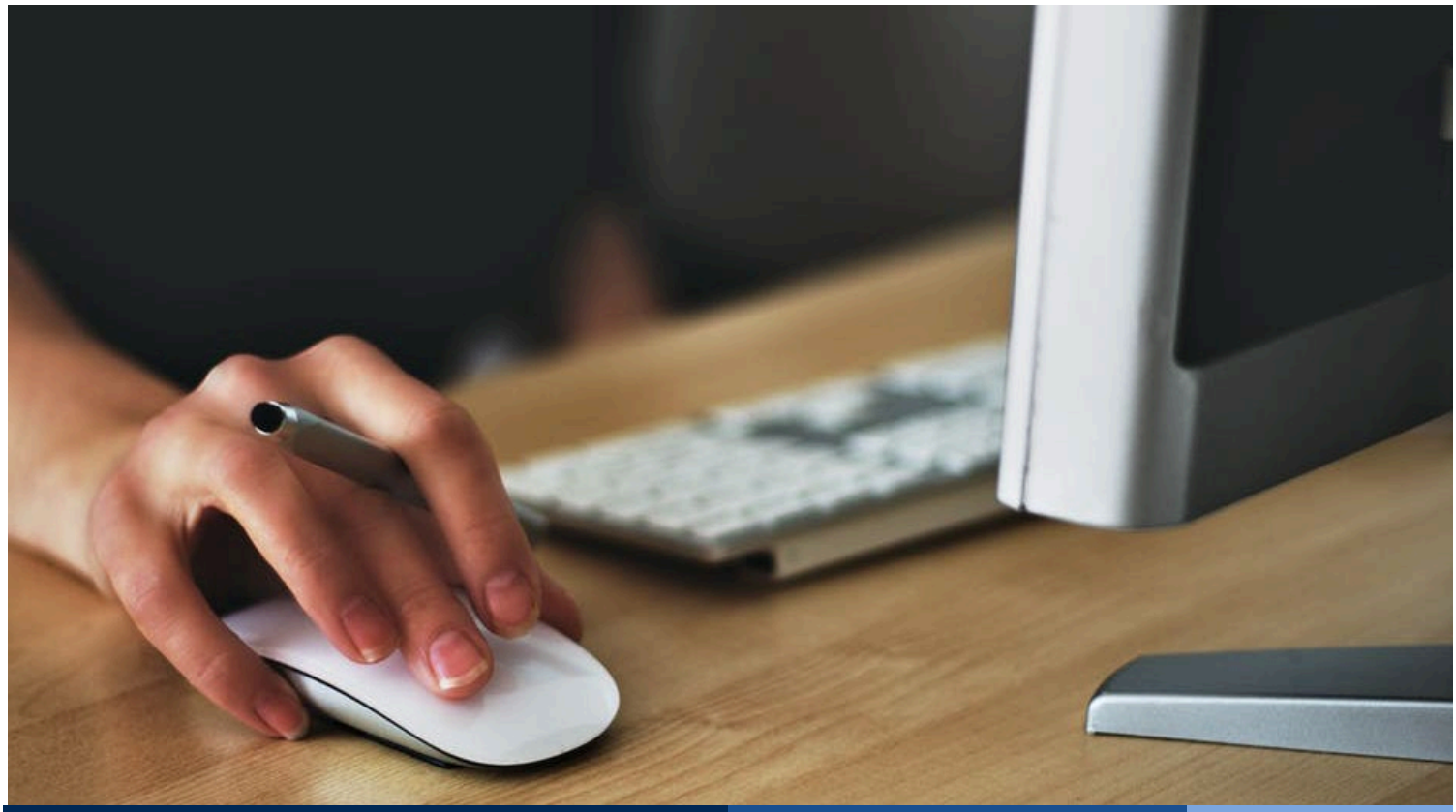
Student Benefit Guide

University of North America

12750 Fair Lakes Circle
Fairfax, VA 22033

Enrollment and Eligibility



The University of North America student plan is provided to all enrolled University students.

All enrolled individuals will soon be receiving new identification cards, if you have not already. If you have any questions regarding your new identification card, please contact the toll-free customer service help-desk at: 1-800-277-8973.

Students become active on the medical policy upon completion of registration/enrollment with the University

Students will remain active on the policy until formal exit of the University or until Graduation date.

Contact Information

Please take time to review this Benefit Guide carefully. If you should have any questions regarding any of the information presented or require additional information about University of North America student benefit program, please contact:

Brown & Brown

Account Manager

Nori Thomas

804- 855 -1073
Nori.Thomas@bbrown.com

Questions	Contact	Email / Website / Phone
Claims/Billing	Benefit Plan Administrators, Inc.	www.bpatpa.com (800) 277-8973
Student ID cards contain Student Plus Plan member information		

Defining Terms

- **Preventive Services**
  Helps you stay healthy – before you have symptoms. Routine checkups and screenings are just two examples. Your health plans pay for covered preventive care without passing costs to you when you see a network doctor.
- **Diagnostic Services**
  When you have symptoms, you need diagnostic care to help find out what's wrong. They may be new symptoms or changes to an ongoing health condition. With diagnostic care, you may need to share some of the costs through a copayment deductible or co-insurance.
- **Deductible**
  The amount you must pay for care before insurance starts contributing. Some services may or may not apply towards the deductible, which will be identified in the benefit summaries.
- **Copayment**
  A copay (or copayment) is a flat fee that you pay for certain services, such as an office visit or to fill a prescription. Copays cover your portion of the cost for these services.
- **Coinsurance**
  A portion of the medical cost after your deductible has been met, and your health plan kicks in. Coinsurance is a way of saying that you and your insurance carrier each pay a share of eligible costs to add up to 100%.
- **Out-of-Pocket Limit**
  For any covered expenses obtained in network, you will never pay more than your maximum out-of-pocket limit during the plan year. The out-of-pocket limit includes all your copayments, deductibles and coinsurance payments. This does not include your premium contribution.

Medical Plan

The student medical plan is arranged through BPA Benefits

Preferred Provider Organization (PPO) Plans allow you to choose to see PPO providers or non-network providers. When you use a provider who participates in the Open POS Network(s) your out-of-pocket expenses for covered services will be lower. Therefore, it is to your advantage to use PPO providers, but it is not required.

MEC Plan Features, Benefit and Coverage

Benefits	Premier MEC
	In Network Only
PPO Network	PHCS
Deductible	N/A
Coinsurance	N/A
Out of Pocket	$7,900/$15,800
Preventive Services for Adults	100% Coverage for Preventative Care Services
Preventive Services for Women	
Preventive Services for Children	
Telephonic Primary Care Services	100%
Office Visit Primary Care Physician	$20 Copay/6 visits per year
Office Chiropractic Care Visit	not covered
Office Visit Specialist	$40 Copay/4 visits per year
Diagnostic X-ray and Lab (in office)	$50 Copay/$750 Max Annual Plan Payment
Cat-Scan/MRI or outpatient testing	$175 Copay/$1,250 Max Annual Plan Payment
Emergency Room	not covered
Urgent Care	$40 Copay/$400 Max Annual Plan Payment
Durable Medical Equipment	$40 Copay/$375 Max Annual Plan Payment
Psychiatric/Substance Abuse Office Visit	not covered
Prescription Drugs +	
Prescription Generic	$10 Copay *(1)*
Prescription Preferred Brand Drugs *(2)*	50% Copay *(1)*
Prescription Non-Preferred Brand Drugs	not covered
Mail Order Copays	not covered

For Emergency Room treatment, please see enclosed legal disclosure.

MEMBER *Guide*

YOUR PHARMACY BENEFITS MADE EASY

Helping you get and remain healthy.

We're here to ensure that your pharmacy benefits are accessible, with ease, when you need them most.

PROACT PHARMACY BENEFIT MANAGEMENT

Customer Service

The ProAct Help Desk is available to serve you 24 hours a day, 7 days a week. Our knowledgeable customer service representatives can assist you with; Benefit Overview, Eligibility, Prior Authorization, and *much more*.

Tel: 877-635-9545
Fax: 315-287-7864
Web: www.ProActRx.com
Email: Support@ProActRx.com
Mail: 1230 US Highway 11
Gouverneur, New York 13642

PROACT PHARMACY SERVICES

Mail Order Pharmacy

ProAct Pharmacy Services will deliver maintenance prescriptions, up to a 90 day supply, directly to your door for the cost of your mail order pharmacy copay. You will need a new prescription from your doctor to begin using the mail service. Your doctor can e-scribe, call in, or fax your prescription to "ProAct Pharmacy Services" (NCPDP #3335468). You may also mail a prescription along with a completed profile form. To get started, call a Help Desk representative to set up your home delivery profile and method of payment.

Tel: 866-287-9885
Fax: 315-287-3330
Web: www.ProActPharmacyServices.com
Email: MailOrder@ProActPharmacyServices.com
Mail: 1226 US Highway 11
Gouverneur, New York 13642

NOBLE HEALTH SERVICES

Specialty Pharmacy

Noble Health Services is ProAct's specialty pharmacy and is available to dispense medications used to treat complex and chronic conditions. Our experts at Noble strive to support patients in all aspects of therapy and always provide the utmost care, from prescription needs and medication therapy management to financial guidance. Emergency on-call support is available at all times via our toll-free number. Your doctor may mail, fax, call, or e-scribe to "Noble Health Services" (NCPDP #5806457). Packages will ship next day delivery to your home, physician's office, or place of business. Same day delivery is available in some areas of Upstate New York. Local members may pick up specialty medications at our facility in Syracuse, New York.

Tel: 888-843-2040
Fax: 888-842-3977
Web: www.NobleHealthServices.com
Email: ContactUs@NobleHealthServices.com
Mail: 6040 Tarbell Road
Syracuse, New York 13206

Welcome to Your PPO Provider Network

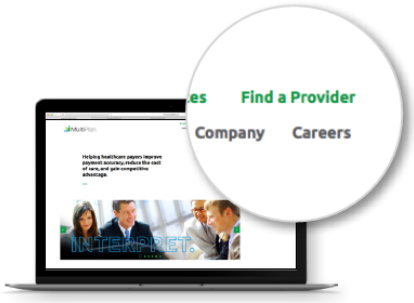
BPA has partnered with **PHCS/Multiplan** and their PPO Provider Network to provide a comprehensive array of physicians and clinics. **Remember, PHCS/Multiplan is not your insurance carrier.** To find a PHCS/Multiplan provider please log onto **www.multiplan.com.**

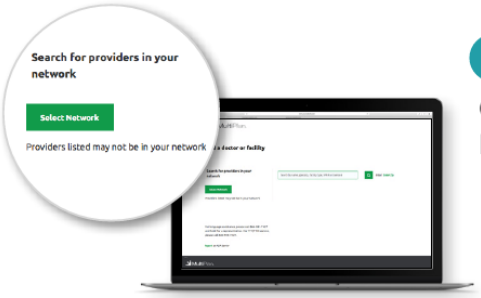
Remember to show your most current ID card to your physician and pharmacist when you visit them for service. Failure to update this information will cause claims to be incorrectly routed for payment. If you need your ID number before you receive your ID card, please contact BPA at 1.800.277.8973.

4 EASY STEPS:

1

On the right side of the screen, select "Find a Provider". You will be prompted to click "OK" to continue.



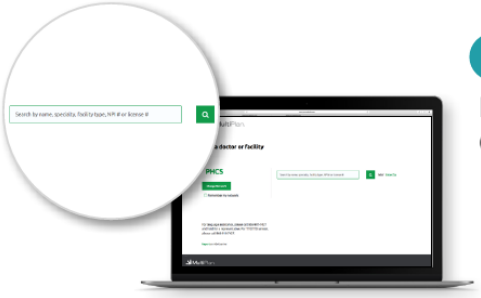


2

Click the "Select Network" Button.

3

You will be asked to identify the network by answering two questions about the network logo on your healthcare ID card.



4

Enter Search Criteria.

If you have questions or need assistance, please contact Customer Service at **1.800.277.8973**, Monday – Friday, 8:00 a.m. – 5 p.m. EST or visit our website at www.bpatpa.com to register and access your health plan information.

Online Member Portal

Our Online Member Portal is an easy-to-use tool that gives you more control of your healthcare through choice, transparency, connectivity and cost savings.

Our Online Member Portal features:

VIEW CLAIMS IN REAL TIME

Do you have questions about details of a recent claim? Our portal allows you to follow the claims process as it happens. You can effortlessly check claims status, see when the claim was paid and even view and print the Explanation of Benefits.

ACCESS UNIQUE CONTENT

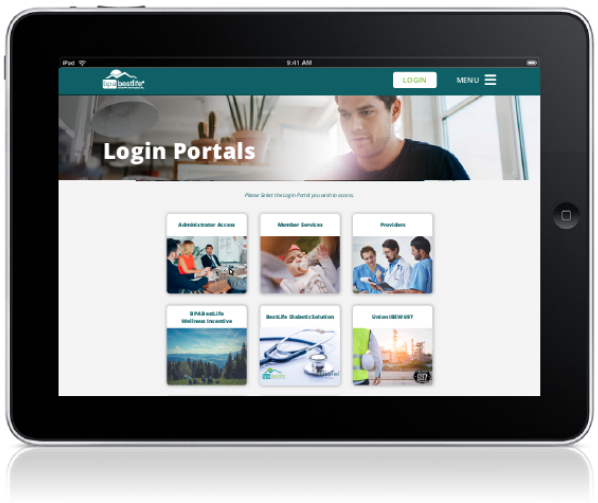
Information at your fingertips – you can find the latest news, announcements and network information. Also, look for plan updates and your personal care plan. You can even find a list of frequently asked questions and a glossary of common terms.

MESSAGE CUSTOMER SERVICE

Easily send questions about eligibility and claims to our customer support team. Changes to your account are simple! You can quickly choose a new primary care physician as well as change your mailing address and request new ID cards.

VIEW ELIGIBILITY AND PLAN INFORMATION

Need to check when benefits are effective? Now you can have your plan information at the click of a button! Our portal can tell you important plan information, such as coverage specifics, deductible information, out-of - pocket amounts and cost-sharing.



Contact BPA Customer Service with questions regarding the BPA Member Portal.

Member Portal Step-by-Step Guide

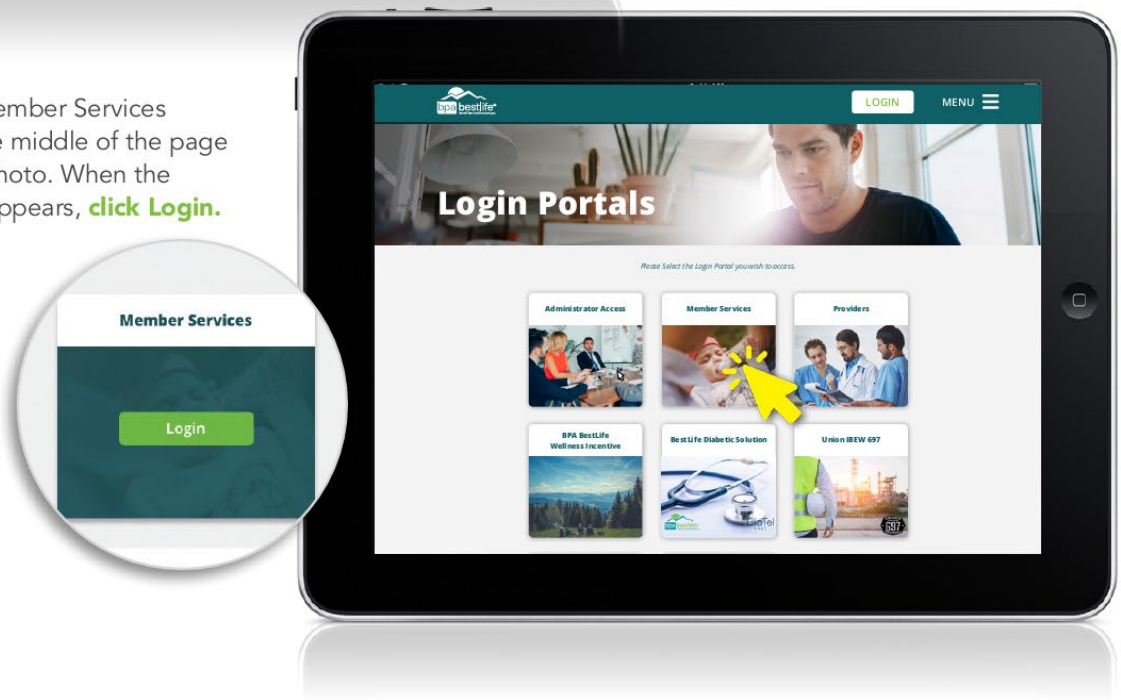
The BPA Member Portal will have live updates to your benefits. Your BPA Member Portal experience will allow access to your claims, eligibility and benefits in real-time.

Follow these steps to easily access your upgraded portal.

1. Go to **www.bpatpa.com**

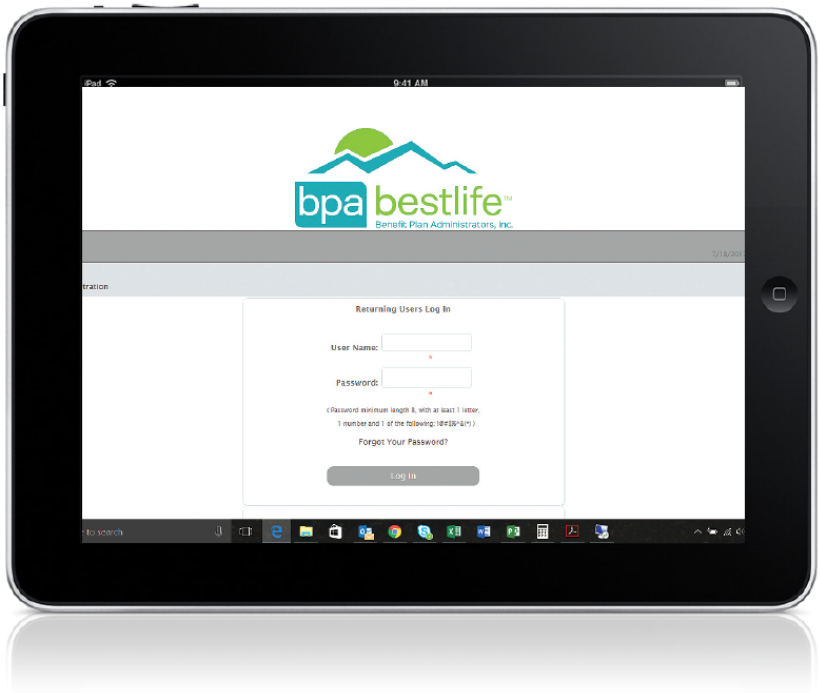
2. Click the **Login button** in the upper right corner of the screen.

3. Scroll down to the Member Services option located on the middle of the page and hover over the photo. When the green Login button appears, **click Login.**



4

Click on the **Register** button, follow the steps to register, and you will have access to your new member account.



5

After registering, you can create your new **username** and **password** and start exploring BPA's real-time Member Portal.

Need a helping hand? Not a problem. If you need assistance accessing your account, please contact BPA Customer Service at 1.800.277.8973, select option 1, Monday – Friday, 8:00a.m. – 5:00p.m. EST.

Member Portal ID Card Request/Print

Once you have registered and logged into the Member Portal, please follow the below steps to request a new ID Card, as well as print/save a PDF copy of your ID Card.

1

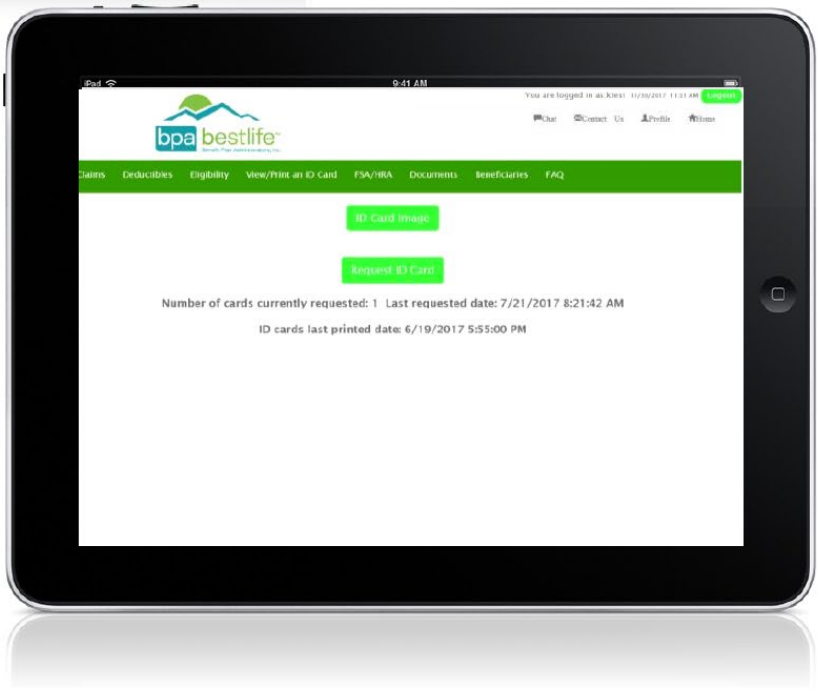
Click on **www.bpatpa.com**

The page will tell you how many times a card has been requested, the last time a card was requested, and the date of the last time an ID Card was printed.

To view/print an ID Card, **select ID Card Image.**

To request a new ID Card be printed, **select Request ID Card.**

A card can also be requested by calling our **Customer Service Department at 1.800.277.8973.**



Teladoc HEALTH

Telehealth Services

www.teladoc.com or Call 877-617-0107

Scan to call

Offering a new front door to healthcare.

Telehealth Services gives members convenient access to quality healthcare when and where they need it. By giving members access to board-certified doctors on demand by phone or video, they have easy access to the care they need from wherever they are.

With Telehealth Services, members with a broad array of healthcare issues can be diagnosed, treated, and prescribed medication if necessary. Telehealth Services provides a new, more cost-effective front door to the healthcare system, so members can feel better faster.

Comprehensive care

Telehealth Services can resolve a broad array of needs, including general medical services, behavioral healthcare, dermatology, and more.

Convenience

Members have 24/7 access by web, phone, or our award-winning mobile app.

Clinical quality

The U.S. board-certified physicians in our network have an average of 20 years' experience and deliver the highest quality care.

4X
greater utilization over industry average

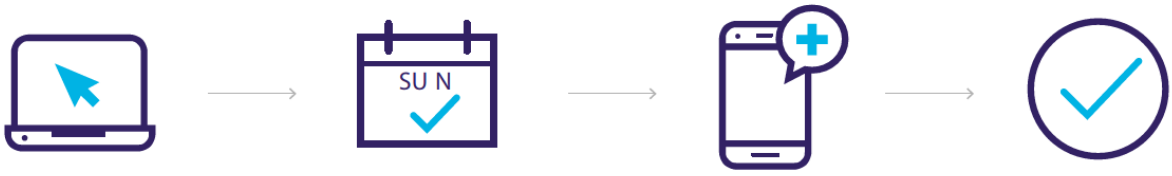
+2.6M
visits annually

2.7M
mobile app downloads

Providing quality healthcare members love, while helping drive medical costs down.

Teladoc HEALTH

How Telehealth Services works



Initiate by app, call, or web

Request a visit

Visit

Resolve

Features

- **General Medical**—Convenient quality healthcare from U.S. board-certified doctors by phone or video.
- **Back Care**—Customized back care programs with videos and access to certified health coaches.
- **Nutrition**—In-depth nutrition consultations and personalized guides for member-specific needs.
- **Tobacco Cessation**—Help from Teladoc physicians and cessation coaches who can prescribe treatment and monitor a member's progress.
- **Behavioral Health Care**—Access to licensed mental health professionals, with the option to receive ongoing care from a provider of their choice.
- **Dermatology**—Access to board-certified dermatologists who can review imagery and prescribe approved medications within days.
- **Global Care**—Convenient, high-quality virtual healthcare for U.S. members traveling abroad.
- **Caregiving**—Allows members to add loved ones to their account and extend the same on-demand access to care.
- **Sexual Health**—Help finding local labs for confidential testing and results for common STIs without the need for an appointment.

"[Teladoc Health's] platform provides a 'one-stop shop' for our members to have real-time access to care."
HR Benefits Executive

"I have used Teladoc twice, and it is the most convenient and cost-effective medical care I have used. The doctors were great and the service was excellent. My issues were resolved."
Teladoc member

TeladocHealth.com | engage@teladoc.com

About Teladoc Health
Teladoc Health is the global virtual care leader, helping millions of people resolve their healthcare needs with confidence. Together with our clients and partners, we are continually modernizing the healthcare experience and making high-quality healthcare a reality for more people and organizations around the world.

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Important Notices

HIPAA Privacy Rights
The Health Insurance Portability and Accountability Act (HIPAA) provides you certain rights to privacy concerning your health information. The regulations designate certain types of information as Protected Health Information (PHI).

Healthcare providers (medical professionals) and health plans, including University of North America health plan representatives, are restricted in their use of PHI to purposes of treatment, payment, and healthcare operations and as required by national public health activities. Written authorization is required to use or disclose your PHI pertaining to your medical, dental, prescription drug, employee assistance program and healthcare spending accounts outside of these purposes.

You may receive a form requesting your authorization to use your PHI for another purpose. Should you grant this authorization, your PHI is still protected from use and disclosure by any party other than the one(s) to whom you grant written authorization, and from use and disclosure by authorized parties for any purpose other than the one you specifically authorized.

Protected Health Information
PHI includes information that could be used to identify you as an individual in electronic, printed or spoken forms that relates to (1) past, present or future health, physical or mental condition, (2) provision of healthcare, or (3) past, present or future payment for the provision of healthcare.

HIPAA gives you the right to:
- Receive notice of the health plan's uses and disclosures of your PHI, your privacy rights and the health plan's legal duties regarding your PHI;
- Obtain access to your own PHI; Amend your PHI;
- Request restriction of the uses and disclosures of your PHI;
- Receive an accounting of non-exempt uses and disclosures of your PHI over the past six years upon request; and
- Receive communications by an alternative means or at an alternate location upon request.

For more information regarding the HIPAA privacy rules, refer to your Summary Plan Description.

HIPAA Privacy Notice Update
HIPAA requires The University of North America Group to notify you that a Privacy Notice is available from the Benefits Department. To request a copy of University of North America Privacy Notice or for additional information, please contact the Human Resources Department at **(571) 633-9651**.

Newborns and Mothers Health Protection Act Rights
Under federal law, group health plans offering group health coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceeded 48 hours (or 96 hours).For information on pre-certification, please refer to your Summary Plan Description.

Women's Health and Cancer Rights Act
University of North America medical plans cover mastectomy-related services. In the case of a participant or beneficiary who receives benefits in connection with a mastectomy, coverage will be provided in a manner determined by 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 services are subject to the same copay deductible provisions that apply to other benefits under University of North America medical plan (as described in this guide).

HIPAA Special Enrollment Rights
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment within 31 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption If you have a new dependent because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Effective April 1, 2009— The University of North America group health plan will allow an employee or dependent who is eligible, but not enrolled, for coverage to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE— If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated because of loss of eligibility.

2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP— If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date your or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Human Resources Department at **(571) 633-9651**.

Summary Plan Description (SPD) Access
This guide does not provide all the details about the benefits programs. More information is available in each program's Summary Plan Description (SPD). In addition to receiving your SPDs after enrolling, they are available at any time from the Human Resources Department at **(571) 633-9651**.
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Summary of Benefits and Coverage (SBC)
Effective for plan renewals after January 1, 2012, the Patient Protection and Affordable Care Act requires employers that offer health coverage to provide a uniform Summary of Benefits and Coverage (SBC) to people who apply for and enroll in the health plan. This document contains the following:

- Four-page overview of plan benefits, cost sharing and limitations
- Required set of examples of how the plan works
- Phone number and internet address for obtaining copies of plan documents
- A Standard glossary of medical and insurance terms must also be available

The SBC will be updated each plan renewal to reflect applicable plan changes.

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

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/ Phone: 1-800-457-4584
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

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 and CHIP**
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)

Important Notices

Continuing Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), University of North America. offers you the opportunity to continue the medical and dental coverage you had as an active employee after it would otherwise end. You and your dependents will receive a COBRA notice in the mail within 14 days of the qualifying event. For more information on COBRA, you may go to www.dol.gov .

You may have other options available to you when you lose group health coverage. For example, you may be eligible to purchase an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30- day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Important Notices

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: 1-800-985-3059 and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: https://scc.virginia.gov/pages/File-Complaint-Consumers or call 1-877-310-6560.
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit https://scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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