2025 -2026 BENEFITS GUIDE

Cowley College

Table of Contents

If you *(and/or your dependents)* have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage.
Please see page 26 for more details.

Welcome!

At Cowley College, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This guide will help you choose the type of plan and level of coverage that is right for you.

You can also view overviews of our benefit plans by logging into the USI mobile app or Paycom.

Sincerely,

Cowley College

Eligible Employees:

You may enroll in our Employee Benefits Program if you are a full-time employee working at least 30 hours per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship,

When Coverage Begins:

The effective date for your benefits is **09/01/2025.** Newly hired employees and dependents will be effective **First of Month Following 30 days of employment.** All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Benefit Questions and/or Elections

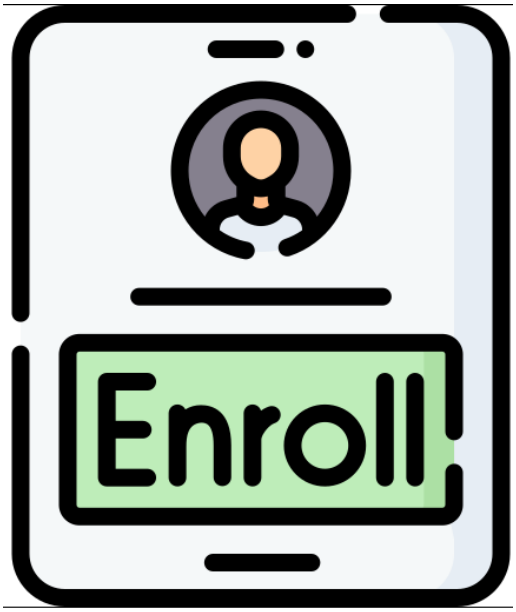
Please contact: Amy Tharp
Email: amy.tharp@cowley.edu
Telephone: 620.441.5295

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Marriage
- Divorce
- Legal Separation
- Birth or Adoption
- Change in Employment Status
- Death of Spouse or Dependent
- Gain or Loss of Insurance

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.



Medical Insurance

BlueCross BlueShield Kansas

	Option 1 $1,000		Option 2 $1,500		Option 3 HDHP $3,500	
Preventive Care	Covered at 100%		Covered at 100%		Covered at 100%	
Telehealth Visits	**$0 copay**		Ded & Coinsurance		Ded & Coinsurance	
Office Visit	$30 copay		80% after deductible		100% after Deductible	
Specialist (includes Eye Exam) Urgent Care	$50 copay		80% after deductible		100% after Deductible	
Emergency Room	$100 copay then Deductible / Coinsurance		$100 copay then Deductible / Coinsurance		100% after Deductible	
Plan Year Deductible						
Individual / Family	$1,000 / $ 3,000		$1,500 / $4,500		$3,500 / $7,000	
Coinsurance	You pay 20% to $1,000 / $3,000		You pay 20% to $1,000 / $3,000		100%	
Out of Pocket Maximum (includes deductible, copays, & coins)						
Individual / Family	$6,350 / $12,700		$6,350 / $12,700		$3,500 / $7,000	
Diagnostic Services						
X-ray and Lab Tests	100% to $300 then Ded. & Coins		80% after Deductible		100% after Deductible	
Retail Prescriptions (34-day Supply)						
Generic	$20 copay or 30% coins up to $200 Maximum		80% after Deductible		100% after Deductible	
Preferred Brand	$40 copay or 30% coins up to $200 Maximum		80% after Deductible		100% after Deductible	
Non-Preferred Brand	$60 copay or 30% coins up to $200 Maximum		80% after Deductible		100% after Deductible	
Specialty Medications Copay assistance available	30% up to a max of $1,000		80% after Deductible		100% after Deductible	
Mail Order Prescriptions (90-day Supply)						
Generic	$50 copay or 30% coins up to $500 Maximum		80% after Deductible		100% after Deductible	
Preferred Brand	$90 copay or 30% coins up to $500 Maximum		80% after Deductible		100% after Deductible	
Non-Preferred Brand	$150 copay or 30% coins up to $500 Maximum		80% after Deductible		100% after Deductible	
	Current Rate	EE Cost	Current Rate	EE Cost	Current Rate	EE Cost
Employee	$855.48	($64.52)	$781.80	($138.20)	$716.71	($203.29)
Employee + Spouse	$1,095.02	$175.02	$999.93	$79.93	$916.84	($3.16)
Employee + Child(ren)	$983.81	$63.81	$898.99	($21.01)	$824.47	($95.53)
Family	$1,180.57	$260.57	$1,078.61	$158.61	$988.68	$68.68

Note: Option 1 & 2 have a 3-month deductible carryover. (Deductible amounts accumulated in June or July will carry over to September). Cowley College provides each employee with a **$920/month** stipend to be used towards medical and dental premiums.

Telemedicine

Telemedicine services allow you to get care whenever you need it. With Amwell, you can have virtual doctor's visits from your computer, tablet, or phone. Amwell is convenient, affordable, private, and secure.

Benefits:

- Available 24/7/365
- Less time away from work
- No travel expenses or time
- Easier if you have a child or elder in your care
- Private and secure

Register for Amwell – for free!
bcbsks.com/telehealth

When can I use it?

- Cold or Flu
- Fever
- Rash
- Sinus Infection
- Pink Eye
- Strep Throat
- Depression
- Anxiety
- Hypertension
- Acne

3 ways to register:

- Download the Amwell app on any mobile device.
- Visit bcbsks.com/telemed
- Call 844-733-3627

Option 1 – $0 copay
Option 2 & 3 – Deductible & Coinsurance

Behavioral Health Services

Licensed therapists can provide advice and counseling for depression, anxiety, stress, relationship issues and more. Private appointments are available 7 days a week, 6:00 a.m. to 10:00 p.m. cst.

Flexible Spending Accounts

A Flexible Spending Account *(FSA)* allows you to pay for a variety of out-of-pocket health care and dependent care expenses pre-tax. Putting money into an FSA before you pay taxes on it saves you money by lowering your taxable income. The result? You pay less in taxes each year. You may also enroll in the Health Care Flexible Spending Account if you have waived medical coverage. Both the Health Care and Dependent Care Flexible Spending Accounts are forfeited when you terminate or are no longer classified as a full-time status employee.

How an FSA works:

- During your open enrollment period, select an annual amount to be taken from each of your paychecks and deposited into your FSA throughout the year (subject to the IRS limits below). Your contributions are taken out of your paycheck before you pay taxes, saving you money. The amount is automatically deducted from your pay at the same level each pay period.

- As you incur eligible expenses, you may use your flexible spending debit card from Basic to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

- On day one of the plan year (September 1), you can use the account to pay or reimburse yourself for expenses up to the total annual amount you elected to contribute for the year. For most transactions, you will need to submit your receipts as substantiation of your expense, so it is important to keep them.

2 Types of FSA's

1. **Health Care Flexible Spending Account** allows you to set aside pre-tax dollars from your paycheck to cover eligible health care expenses such as eyeglasses, contacts, copays, deductibles, prescription medications, and orthodontia. The entire amount you set aside is available to use on the first day of your plan year. To view a list of Eligible Expenses for your FSA, visit **www.fsastore.com**.

2. **Dependent Care Flexible Spending Account** allows you to set aside pre-tax dollars from your paycheck to cover eligible dependent care expenses such as day care, babysitting and general-purpose day camps for your dependents under the age of 13 while you are at work. You can also use the funds to pay for adult day care services for dependent adults who are unable to care for themselves (if they live with you for at least eight hours per day). You will be reimbursed for eligible expenses as they are incurred and as funds are deposited into your account.

How Much Can I Contribute?

- There are limits on the amount you can contribute to FSAs in 2025:
- Health Care FSA - a maximum of **$3,300**
- Dependent Care FSA - a maximum of $**5,000** or $2,500 if married and filing separately

FSA Account Expenses

You can use your account funds for numerous healthcare-related products and services - for yourself, your spouse, and your qualifying child or relative. The IRS rules state that expenses reimbursed under your health FSA may not be reimbursed under any other plan or program, and only your qualified out-of-pocket expenses are eligible. These expenses must be incurred within the coverage period specified by your plan.

Eligible Expenses	
Acupuncture and chiropractic services	Insulin, diabetic supplies, test kits
Birth control pills, condoms, contraceptive devices	Medical test and other medical services
Co-pays, co-insurance, and deductible	Mileage to and from medical services
Crutches, wheelchairs, other medical durable equipment	Orthodontia
Dental exams, cleanings, fillings, other dental expenses	Over-the-counter medications and care items
Eye exam, vision correction surgery, eyeglasses, contacts and solutions	Prescriptions
Hearing devices	X-Rays
Hospital bills	And more

Standard documentation required

- Explanation of Benefits *(EOB)*,
- Provider's statement of services provided, or itemized receipt
- Documents must include a patient's name, date of service or purchase, provider or merchant name, description or product name, and cost of service or product.

Other Points to Remember...

- You must re-enroll in the Flexible Spending Account(s) each year in order to participate.
- The FSA allows a 2 ½ month grace period at the end of the plan year to file for claim reimbursement.
- Eligible medical expenses must be incurred from September 1 through August 31 each year.
- All claims and receipts must be submitted by November 15, 2027, for expenses incurred in the 2025 plan year.
- Each of these accounts are separate. You can choose to participate in both, one, or neither. The rules and regulations of the IRS govern all FSA accounts.

Questions
Tel: (800) 444-1922 x 3
Website: basiconline.com

Download our free mobile app for Apple and Android Devices! Search for "BASIC benefits app"

Health Savings Account (HSA)

When you are enrolled in a Qualified High-Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don’t pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High-Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High-Deductible Health Plan (QHDHP) – **Option 3**
- You must not be covered by another non-QHDHP health plan, such as a spouse’s PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as dependent on another person’s tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse’s FSA. (Enrollment in a limited purpose health care FSA is allowed).

2025 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

2025 HSA Contribution Limits

$4,300 Individual/$8,550 Family

**If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.*

Dental Insurance

The chart below is a brief outline of our plan through Blue Cross Blue Shield of KS. Please refer to the summary plan description for complete plan details.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

Dental Benefit	In Network
Annual Deductible	**$25** *(Individual)* **$75** *(Family)*
Annual Maximum	**$1,500**
Dependent Children Covered – up to age 26. **Services for children 12 & under paid at 100%**	
Preventive Dental Exam – 2 per year	Paid 100%
Primary Services Oral surgery Endodontics Simple Extractions	Paid at 50%
Major Services Periodontal Onlays Bridges Crowns	Paid at 50%
Orthodontia	Not Covered
Employee Cost	**Deductions (12)**
Dental	
Employee only	$32.30
Employee & Spouse	$69.47
Employee & Child(ren)	$63.73
Family	$100.50

BlueCross BlueShield Kansas

Vision Insurance

The chart below is a brief outline of the vision plan. Please refer to the summary plan description for complete details.

Benefit Coverage	In-Network Services
Routine Exams (once every plan year)	$10 copay
Frame (once every plan year	**20% off balance over $180 Allowance**
Plastic Lenses (in lieu of contats once every plan year)	
Single Vision	$25 copay
Bifocal	$25 copay
Trifocal/Lenticular	$25 copay
Progressive – standard	$80 copay
Progressive – Premium Tier I, II, or III	$110, $120, or $135 copay
Progressive – Premium Tier IV	$240 copay
Lens Option	
Anti Reflective Coating – Standard	$45 copay
Anti Refective Coating -Premium Tier I, II, or III	$57, $68, or $100 copay
Contacts (in lieu of contats once every plan year)	
Conventional	$0 copay; 15% off balance over $180 allowance
Disposable	$0 copay; 100% off balance over $180 allowance
Medically Necessary	$0 copay; paid in full

Employee Cost	Deductions (12)
Vision	
Employee	$9.22
Employee & Spouse	$17.52
Employee & Child(ren)	$18.44
Family	$27.11

Additional Discounts:

- 40% off additional pairs of glasses
- 20% off any item not covered by the plan, including non-prescription glasses
- 15% off retail price or 5% off promotional price for Lasik or PRK from US Laser Network
- Up to 64% off aids, with extended warranty and free batteries through Amplifon Hearing Care Network.

VISION CARE SERVICES	IN-NETWORK MEMBER COST
EXAM SERVICES	
Retinal Imaging	Up to $39
CONTACT LENS FIT AND FOLLOW-UP	
Fit and Follow-Up – Standard	Up to $40
Fit and Follow-Up – Premium	10% off retail price
LENS OPTIONS	
Photochromic – Non-Glass	$75
Polycarbonate – Standard	$40
Scratch Coating – Standard Plastic	$15
Tint – Solid or Gradient	$15
UV Treatment	$15
All Other Lens Options	20% off retail price

Optional Group Life with KPERS (OGLI)

As part of your KPERS benefits, your employer offers Optional Life Insurance, additional coverage beyond KPERS basic life insurance. This is extra coverage to help you protect what matters most – your family, including their financial security. With Optional Life, you decide how much you need and pay your premiums through payroll deduction.

Employee	
Benefit Amount	Increments of $5,000
Maximum Amount	$400,000
Guarantee issue Amount	$50,000 to $250,000
Spouse	
Benefit Amount	Increments of $5,000
Maximum Amount	$100,000
Guarantee issue Amount	$25,000
Child(ren)	
Benefit Amount	Increments of $10,000 or $20,000
Maximum Amount	$20,000
Guarantee issue Amount	$10,000 or $20,000

One Premium covers all eligible children in your family up to the age of 26. No age limit with disabled dependents.

What to do next

To start new or increase current coverage, login to your KPERS online account and enroll during your open enrollment dates.

Go to Kpers.org ➡click the blue Member Login button ➡login to your account.
First time users can enroll for KPERS online account access in three steps.
Click the New User Link. It will take about three minutes, and you'll only have to do it once.

More Information

Check out the decision support tool at www.standard.com/edu/kpers/15851 to learn more:

- ✓ Benefit videos
- ✓ Rates and coverage
- ✓ Claim example
- ✓ Life insurance needs calculator

Contact The Standard

Toll Free- 1-844-289-2306
Email: kpersadmin@standard.com

KPERS

AFLAC's Term Life to Age 120

Aflac Group Life Term to 120 offers guaranteed-issue living and death benefits, with the predictability of a whole-life plan, at rates that won't increase, allowing you to help prepare your family for a financially secure future.

Aflac Group Life Term to 120 Benefit Coverage Options:

- Employee
- Spouse

Plan Features:

- You may apply or guaranteed-issue benefit amounts without any medical questions.
- Premiums will not increase
- Benefits may be paid directly to your named beneficiary.
- Once your Term Life insurance application has been approved and payroll deductions have started, the coverage is yours to keep as long as you continue to pay premiums.
- Coverage is portable (with certain stipulations), which means you can take it with you if you change jobs or retire.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Coverage Type	Guaranteed Issue Only
Spouse Coverage	Included
Child Coverage	Included
Guaranteed-Issue Amounts	**Employee:** Up to $50,000 **Spouse:** Lessor of $25,000 or 50% of Employee benefit **Child:** $25,000 **Participation Requirement:** 10%

Benefits Overview

Death Benefit (Employee and Spouse (see eligibility) coverage available). In the event of the insured's death, a one-time Lump sum Death Benefit payment will be paid to the beneficiary.

For more information, ask your insurance agent/producer or call (800) 433-3036.

Short Term Disability

College will provide short-term disability through AFLAC effective 9/1/25. This plan provides you with a benefit in the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive disability benefits if you are receiving workers' compensation benefits. Short Term Disability is paid 100% by the employee and benefits begin after the applicable elimination period is satisfied and continue during disability, up to the disability period.

	Option 1	Option 2	Option 3
Coverage Amount	60% of your earnings to a maximum $4,000 /monthly		
Elimination Period	Injury: 0 days Sickness: 7 days	Injury: 14 days Sickness: 14 days	Injury: 30 days Sickness: 30 days
Maximum Duration	26 weeks	26 weeks	26 weeks
Pre-Existing Limitations	None		

Option 1 Rates

Monthly Rates per $100 of monthly benefit			
Age Band	18-49	50-64	65-74
Premium Rate	$3.36	$3.46	$4.36

Option 2 Rates

Monthly Rates per $100 of monthly benefit			
Age Band	18-49	50-64	65-74
Premium Rate	$1.97	$2.17	$2.69

Option 3 Rates

Monthly Rates per $100 of monthly benefit			
Age Band	18-49	50-64	65-74
Premium Rate	$1.16	$1.43	$1.79

Note: No EOI is required if you do not enroll at your first opportunity.

Accident Plan

An Accident Insurance plan supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. The plan pays you directly regardless of any other payments you may receive from your medical plan. Benefits are paid for fractures, dislocations, burns, concussions, emergency care, medical testing, transportation, and more. The plan will pay for injuries sustained on or off the job and is available for employees, spouses and child(ren).

Accident Plan - AFLAC	
Benefit	**Amount**
Ambulance *(ground/air)*	$400 / $1,200
Concussion	$500
Coma	$10,000
Dislocations	Up to $4,000
Emergency Dental Work	$50 Extraction $200 Repair with a crown
Facility Fee for Outpatient Surgery	$100
Fractures	Up to $4,000
Inpatient Surgery and Anesthesia	$1,000
Outpatient	$400

The plan also pays a $50 Health Screening Benefit per covered person, per calendar year.

Monthly Premiums			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$19.84	**$31.40**	**$39.64**	**$51.20**

See Certificate of Coverage for additional coverage details and exclusions.

Critical Illness Plan

A Critical Illness plan provides a lump-sum cash benefit upon diagnoses of a critical illness like a heart attack, stroke or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily living cost. This coverage is Guaranteed Issue when you are first eligible to enroll, which means there aren't any medical questions! If you enroll after your initial eligibility, you will be required to complete evidence of insurability.

	Benefit Amounts	Guaranteed Issue
Employee	$20,000	Increments of $5,000 up to $20,000
Spouse	*50% of Employees Election*	
Child(ren)	*50% of Employees Election*	

Covered Conditions	% of Benefit
Cancer, Heart Attack, Stroke, Kidney Failure, Bone Marro Transplant, Sudden Cardiac Arrest, Major Organ Transplant, Coma, Paralysis, Loss of Sight, Loss of Hearing, Loss of Speech, Benign Brain Tumor, Type I Diabetes, Coronary Artery Bypass Surgery.	**100%**
Non-Invasive Cancer, Metastatic Cancer	**25%**

Additional Plan Details:

- **Additional Diagnosis Benefit:** The plan will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.
- **Reoccurrence Benefit:** The plan will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.
- **Skin Cancer Benefit:** The plan pays $1,000 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.
- **Health Screening Benefit:** The plan pays a $50 Health Screening Benefit per calendar year.

Monthly Premiums (Employee)				
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**
Age 18-25	$2.52	$5.05	$7.57	$10.10
Age 26-30	$3.29	$6.58	$9.87	$13.16
Age 31-35	$4.11	$8.22	$12.33	$16.44
Age 36-40	$5.21	$10.41	$15.62	$20.82
Age 41-45	$6.67	$13.35	$20.02	$26.70
Age 45-50	$8.65	$17.30	$25.96	$34.61
Age 51-55	$13.27	$26.53	$39.80	$53.07
Age 56-60	$15.89	$31.77	$47.66	$63.55
Age 61-65	$25.62	$51.24	$76.85	$102.47
Age 66+	$40.63	$81.25	$121.88	$162.51

Monthly Premium (Spouse)			
Age	**$5,000**	**$7,500**	**$10,000**
Age 18-25	$2.52	$3.79	$5.05
Age 26-30	$3.29	$4.94	$6.58
Age 31-35	$4.11	$6.16	$8.22
Age 36-40	$5.21	$7.81	$10.41
Age 41-45	$6.67	$10.01	$13.35
Age 45-50	$8.65	$12.98	$17.30
Age 51-55	$13.27	$19.90	$26.53
Age 56-60	$15.89	$23.83	$31.77
Age 61-65	$25.62	$38.43	$51.24
Age 66+	$40.63	$60.94	$81.25

Child Rate: No additional premium as long as EE/Child or Family coverage is elected.

Hospital Plan

Without any warning, an illness or injury can lead to a hospital visit – and costly out-of-pocket expenses. The Hospital Indemnity plan supplements your medical coverage and provides a cash benefit for hospital admissions and confinements. This benefit is paid directly to you and can be used to pay out-of-pocket medical expenses; help supplement your daily living expenses and cover unpaid time off work. This coverage is available for employees, spouses and child(ren) and is administered by AFLAC.

How it works

Amount payable was generated based on benefit amounts for: Hospital Admission ($1,000), and Hospital Confinement ($150 per day).

Benefit Amount	Amounts
Hospital Admission Once per covered sickness or accident per covered person, per calendar year	$1,000 per admission
Hospital Confinement Maximum period: 31 days per covered sickness or covered accident	$150 per day
Hospital Intensive Care Benefit Maximum of 10 days per confinement for each covered sickness or accident for each insured	$150 per day
Intermediate Intensive Care Step-Down Unit Maximum of 10 days per confinement for each covered sickness or accident for each insured	$75 per day
Successor Insured Benefit If spouse overage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time	$75

Monthly Premiums			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$17.94	**$36.16**	**$28.70**	**$46.92**

See Certificate of Coverage for additional coverage details and exclusions.

Retirement Plan 403(b)

Cowley's 403(b) Savings Plan is a tax-deferred retirement plan which allows you to contribute a percentage of your pay before taxes and receive a basic contribution and matching contribution from Cowley College. Distributions generally are only available when you reach age 59 ½. However, distributions can also be available in the event of financial hardship, death or disability.

You can contribute up to 100% of your compensation to this plan, up to the limit allowed under the Internal Revenue Code which is $22,500 in 2023. The combined employee and employer contribution limit is $66,000. If you are age 50 or older, you can make a "catch-up" contribution of up to $7,500 in 2023.

Automatic payroll deduction withdraws your contribution directly from your paycheck after you complete a Salary Deduction Agreement and return it to your financial representative. You may commence making contributions or modify the amount of your current contribution at any time.

You may choose the 403(b) custodial account or annuity contract you want from the list of approved investment providers and 403(b) investment products located on the Bay Bridge website. **http://sfr.baybridgeadministrators.com.**

Ameriprise Financial Services
(800) 297-7378
70100 Ameriprise Financial Cntr
Minneapolis, MN 55474

Aspire Financial Services
(866) 634-5873
4010 Boy Scout Blvd, Ste 500
Tampa, FL 33607

Voya Retirement Ins
PO BOX 3015
New York, NY 10116
(888) 410-9482

Security Benefit (800-888-2461)
Ginger Hamilton
(316) 670-0049
ginderhamilton@ofgfinancial.com

Ian Lindstrom
(316) 990-8923
ianlindstrom@ofgfinancial.com

Leasha Rutschman
(316) 461-5063

Additional Resources

USI Mobile App

Check out on-the-go access to your key benefit information through the USI Mobile App, **MyBenefits2GO**. Download it to the App Store or Google Play Store and enter **code M91455** in the app to access your benefit highlights.

Have Questions? Need Help?

Employees have access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Central Standard Time at **855-874-0742** or via e-mail at BRCMT@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier Customer Service

	CARRIER	PHONE NUMBER	WEBSITE
Medical & Dental Plan *Policy #07684*	Blue Cross and Blue Shield of Kansas	(800) 432-3990	www.bcbsks.com
Telemedicine	Amwell	(844) 733-3627	Bcbsks.com/telemed
Vision	EyeMed	(866) 939-3633	Eyemed.com
Flexible Spending Account & Health Savings Account	BASIC	(800) 444-1922 x 3	Basiconline.com
Vol Life, Accident, Critical Illness, Hospital Plan & Group Term Life	AFLAC	(800) 433-3036	Aflacgroupinsurance.com
Vol Life Insurance	KPERS	1-844-289-2306	kpersadmin@standard.com
Benefit Resource Center (BRC)	USI	(855) USI-0742	BRCMT@USI.com
HR Department	Amy Tharp	(620) 441-5295	amy.tharp@cowley.edu

This brochure summarizes the benefit plans that are available to Cowley College eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. The information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

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

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance. To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTACT INFORMATION

Amy Tharp
125 S. 2nd
Arkansas City, KS 67005
620-441-5295
Amy.Tharp@cowley.edu

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Date provided: 9-1-2025
- Amy Tharp (620) 441.5295

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Cowley College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cowley College 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. **Cowley College has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Kansas 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 Cowley College coverage will not be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

If you do decide to join a Medicare drug plan and drop your current Cowley College coverage, be aware that you and your dependents will 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 coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cowley College changes. You also may request a copy of this notice at any time.

OMB 0938-0990

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).

[Optional Insert – Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]

Medicare Eligible Individual's Name: [Insert Full Name of Medicare Eligible Individual]
Individual's DOB or unique Member ID: [Insert Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]
From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date:	9-1-2025
Name of Entity/Sender:	Cowley College
Contact--Position/Office:	Amy Tharp | Payroll & Benefits Coordinator
Address:	125 S 2nd St, Arkansas City, KS 67005
Phone Number:	(620) 441-5295

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, 2023. 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://kidshealth.ky.gov/Pages/index.aspx 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
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 July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact .

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Cowley College	4. Employer Identification Number (EIN) 48-0720889	
5. Employer address 125 S 2nd Street	6. Employer phone number 620.441.5295	
7. City Arkansas City	8. State KS	9. ZIP code 67005
10. Who can we contact about employee health coverage at this job? Amy Tharp		
11. Phone number (if different from above) 620.441.5295	12. Email address Amy.tharp@cowley.edu	

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

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:

    Full-time employees working 30 or more hours per week

    Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legal spouse of employee; natural, adopted, or step children up to age 26; children who are older than 26 and disabled
  - ☐ We do not offer coverage.

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

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

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

* An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.