LOYOLA
UNIVERSITY MARYLAND

Employee Benefits Guide

Full-time Temporary Biweekly Staff, Administrators, and Faculty
July 1, 2025 - June 30, 2026

Enrolling in Your Benefits

Before you enroll:

Familiarize yourself with your options by reading the benefits described in this guide. Details regarding all of Loyola's benefits are located on the HR Benefits website at www.loyola.edu/department/hr/benefits.

If you are in need of additional assistance, please contact the Benefits & Wellness Unit at x1365.

Ready to enroll:

You will receive an email notification during the new hire on-boarding process. Simply click the link in the notification or log on to ***Inside Loyola*** at https://inside.loyola.edu and select the Workday icon located in the *Resources for Employees* section.

Please contact Technology Services for technical assistance. If you do not know your username and password, please contact ots@loyola.edu for assistance.

New Hires—please note...

You will have access to the Workday benefits enrollment system once you receive the Workday Benefits Hire Task. You have 30 days to complete your enrollment.

This communication highlights some of the benefit plans available. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the official plan documents will always govern. The University reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

If you have any questions about your benefits you may contact Loyola's Benefits & Wellness Unit, the insurance carrier, or PSA Insurance & Financial Services. PSA is a consulting firm chosen by Loyola to assist with the administration and selection of your benefit plans.

PSA can be reached Monday through Friday, 8:30 a.m.–5 p.m. at 1-877-716-6618 or via email at loyola@psafinancial.com.

Important Notice about Your Prescription Drug Coverage & Medicare–please see page 10.

Please read it and share it with any of your Medicare-eligible dependents.

Eligibility

Employees

Temporary staff, administrators, and faculty working a minimum of 30 hours per week on a regular basis (including other groups as defined in the plan document) are eligible to participate in benefits noted and described in this brochure. Benefits for newly hired employees are effective on the first of the month following 60 days of employment.

Eligible Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents. Eligible dependents are defined below:

- **Spouse:** a person to whom you are legally married by a ceremony
- **Legally Domiciled Adult (LDA):** Domestic partner or dependent relative that meets eligibility criteria (LDA affidavit must be completed and returned to the Benefits & Wellness Unit)
- **Child(ren):** Eligible to age 26 regardless of student status, financial dependency, or marital status

Change-in-Status Events

Please keep in mind that benefit elections and their related payroll deductions cannot be changed until the next Open Enrollment period unless you, your spouse, or your dependent child(ren) experience a qualified change-in-status event. Change-in-status events are changes in the below:

- Legal marital status, including marriage, death of a spouse, divorce, and annulment
- Number of covered dependents due to birth, death, adoption, granting of legal custodianship, or reaching maximum age for coverage
- Employment for you, your spouse, or your dependent, including commencement of or return from leave of absence, or change in employment status
- Eligibility for other coverage, or loss thereof, due to spouse's Open Enrollment period, or loss or gain of benefit eligibility

The benefits plan year runs July 1 to June 30. You will not be able to make changes to your elections during the plan year unless you experience a change-in-status event. If you do not experience a change-in-status event, the elections you make will remain in effect until **June 30, 2026**.

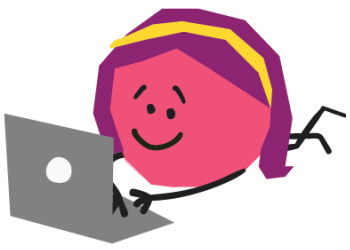
You must notify your Benefits & Wellness Unit within 30 days of the change-in-status event in order to make a change to your benefit elections. Documentation supporting the change will be required.

Annual Payroll Deductions

You must complete the wellness requirements within 120 days of eligibility or within the previous eight months prior to the date of eligibility. If you do not complete all of the required steps, the "wellness non-compliant" rates will go into effect on the first of the fifth month following date of eligibility. See page three for more details.

**** IMPORTANT PAYROLL DEDUCTION INFORMATION:***
If you miss a paycheck or do not earn a full paycheck, you are still responsible for paying your benefits premiums. Loyola will begin to recoup the premiums due when you have your next paycheck.

Medical	OAP HSA (HDHP)	
	Wellness	Non-Wellness
Employee Only	$1,339.20	$2,819.28
Employee + Spouse	$5,304.36	$8,264.52
Employee + Child	$3,442.32	$4,922.40
Employee + Children	$4,669.92	$6,150.00
Family	$7,981.68	$10,941.84



Medical Overview

Keeping you and your family in good health.

The health benefits available to you represent a significant component of your compensation package, and they provide important protection to keep you and your family in good health. The University is pleased to offer your OAP HSA (HDHP) medical plan that through **Cigna**.

The OAP HSA (HDHP) plan offers the flexibility to choose from both in and out-of-network providers, but keep in mind that if you receive care from an out-of-network provider you will be subject to higher out-of-pocket costs and balance billing by the provider.

Need more information about your medical plans or other benefits?

There are a number of resources on the University's HR/Benefits website at **www.loyola.edu/department/hr/benefits**.

Summary of Benefits and Coverage (SBC)

Choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC), which summarizes important benefit information in a standard format, is available for the medical plan option. The SBC is located on the Benelogic website, under the Resources tab, and at **www.loyola.edu/department/hr/benefits**. A paper copy is also available, free of charge, by contacting the Benefits & Wellness Unit.

Save money on your medical plan premiums by completing the wellness steps before October 31, 2025.

Current employees and their spouses/LDAs insured under the medical plan can qualify for reduced medical plan premiums. You and your covered spouse/LDA must complete the following steps to qualify:

- Health Assessment on the MyCigna website
- Annual Physical exam

New hires or newly eligible employees must complete their wellness steps within 120 days from their benefit start date.

Sign in at myCigna.com to complete your wellness steps or contact a Cigna representative at 1-800-244-6224 for help.

Omada Programs

Interested participants can visit omadahealth.com/omadacomplete and complete the survey to learn if they meet the necessary risk factors to qualify for one of the following programs.

- Cigna's Diabetes Prevention Program - Join this program to help avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke.
- Omada for Diabetes - Participants diagnosed with Diabetes can improve their blood glucose levels, reduce the risk of diabetes distress and self-manage diabetes medication.
- Omada for Hypertension - Participants diagnosed with high blood pressure can improve their blood pressure levels, and reduce cardiovascular risks.

Medical and Prescription Plan Highlights

The features of your medical plan through **Cigna** are highlighted in the chart below. Please refer to your plan description for full details. This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. ***You are responsible for copayments, coinsurance, and all charges that exceed the allowed amount for services received out-of-network.***

	OAP HSA (HDHP)	
	In-Network YOU PAY	**Out-of-Network YOU PAY**
Network	Open Access Plus	N/A
PCP Required?	No	
Referrals Required?	No	
Annual Deductible	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000
Annual Out-of-Pocket Maximum	Individual: $5,000 Family: $9,200	Individual: $9,000 Family: $18,000
Well Child Care, Adult Physical, Routine GYN Visit, Mammogram	No charge	Deductible, then 30%
Office Visits PCP/Specialist	Ded., then $25 copay/ Ded., then $50 copay	Deductible, then 30%/ Deductible, then 30%
X-Ray and Laboratory	Deductible, then 10%	Deductible, then 30%
Allergy Shots PCP/Specialist	Deductible, then 10%	Deductible, then 30%
Rehabilitation Services (Physical, Speech, Occupational) *limited to 100 visits per plan year combined*	Deductible, then 10%	Deductible, then 30% (speech*)
Emergency Room *copay waived if admitted*	Deductible, then $300 copay	
Urgent Care	Deductible, then $75 copay	Deductible, then 30%*
Inpatient Facility	Deductible, then 10%	Deductible, then 30%*
Inpatient Physician	Deductible, then 10%	Deductible, then 30%*
Outpatient Facility	Deductible, then 10%	Deductible, then 30%*
Outpatient Physician	Deductible, then 10%	Deductible, then 30%*
Inpatient Hospitalization	Deductible, then 10%	Deductible, then 30%*
Office Visits	Deductible, then 10%	Deductible, then 30%*
Partial Hospitalization	Deductible, then 10%	Deductible, then 30%*

Prescription Drugs		
Deductible	Medical deductible applies	
Retail		
up to 34-day supply	Copays apply once the deductible is met:	
Generic	$10 copay	30%
Preferred Brand	$35 copay	30%
Specialty & Non-Preferred	$80 copay	30%
90- day supply	Copays apply once the deductible is met:	
Generic	$20 copay	30%
Preferred Brand	$70 copay	30%
Specialty & Non-Preferred	$160 copay	30%
Home Delivery		
90-day supply	Copays apply once the deductible is met:	
Generic	$20 copay	Not covered
Preferred Brand	$70 copay	Not covered
Specialty & Non-Preferred	$140 copay	Not covered

Need to locate a provider?

Go to **www.cigna.com** and select "Find a Doctor, Dentist, or Facility." Choose "Employer or school" and enter your search location to search by doctor type, name, or location. Log in or search as a guest and select the Open Access Plus plan (you will use the Open Access Plus network for all three plan options).

Preventive Care

Preventive Care is covered in full when received in-network. Preventive care services include adult routine physical, well-child care visits, immunizations, routine GYN visits, age and gender appropriate cancer screenings, and other preventive services as required by the Affordable Care Act. These preventive services are covered in full when seeing a participating, in-network Cigna provider.

Evernorth Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways we can work through them. Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna offers a variety of behavioral support tools and services to help ensure you get support, including the below:

- Virtual counseling
- Emotional health and well-being
- Mental health
- Substance use
- Coaching and support
- Lifestyle management programs

For more information, visit **www.mycigna.com** or call the phone number on the back of your ID card.

Cigna Member Resources

Getting the most from your plan

When you're better informed, it can help you make better choices. Cigna's personalized website, **www.mycigna.com**, provides access to your plan information, as well as many online tools with information to help you make more informed health decisions. Want to find out how to improve your fitness or eat better? Cigna's online tools can help you stay active and take care of your health.

Cigna Mobile app

The myCigna mobile app gives you an easy way to organize and access your important health information—anytime, anywhere. Download the free app and gain instant access to multiple services.

Nurse Line

The 24-Hour Health Information Line (HIL) assists individuals in understanding the right level of treatment at the right time at no cost to you. Trained nurses are available 24 hours a day, seven days a week, 365 days a year to provide health and medical information and direction to the most appropriate resource. To speak with a nurse, call 1-866-494-2111.

Know Before You Go—When You Need Care

Your Doctor Knows Best

- Your primary care physician (PCP) knows your health history.
- Having a personal physician can result in overall better care.

But what if you get sick or injured when your doctor's office is closed?

Cigna Members: 24/7 Medical Advice

- Health Information Line: get advice on a diagnosis or where to receive care.
- Cigna Virtual Care: access virtual doctor visits for common, uncomplicated, non-emergency health issues.

Urgent Care Centers (e.g. Patient First or ExpressCare)

- Urgent care centers are usually open after normal business hours, including evenings and weekends.
- Many urgent care centers offer on-site diagnostic tests.
- Save time and money by going to urgent care instead of the ER.

Emergency Room (ER)

- This is the best place for treating severe and life-threatening conditions; ERs are not staffed to focus on minor injuries.
- ERs provide the most expensive type of care.

These are general guidelines. Call 911 or go straight to the ER if you have a life-threatening injury, illness, or emergency.

Cigna Virtual Care

Care when you need it

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to medical and behavioral/mental health virtual care. With Cigna Virtual Care, you can get the care you need—including most prescriptions—for a wide range of minor conditions. Visit **www.mycigna.com** and log in to get started.

You can connect with a board-certified doctor when, where, and how it works best for you—via video or phone—without having to leave home or work. MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. HSA plan participants will pay a $55 copay for a virtual visit prior to meeting their deductible.

Whether it's late at night and your doctor or therapist isn't available, or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone
- Get medical virtual care 24/7/365—even on weekends and holidays
- Schedule a behavioral/mental health virtual care appointment online in minutes
- Connect with quality board-certified doctors and pediatricians, as well as licensed counselors and psychiatrists
- Have a prescription sent directly to your local pharmacy, if appropriate

Now, you can even have virtual wellness/preventive screenings at no cost through MDLIVE. Simply make a virtual visit appointment online and then visit a lab for your blood work and biometrics. You will receive a notification when the results are available in the MDLIVE customer portal. Prior to your virtual appointment, your results must be shared with the MDLIVE provider so that your visit will be more focused and informative.

You have options

- MDLIVE: medical and behavioral/mental health virtual care: 1-888-726-3171
- Evernorth Behavioral Health also provides access to video-based counseling through Cigna's network of providers. To find a provider:
  - Visit **myCigna.com**, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type"
  - Call the number on the back of your Cigna ID card 24/7

Download the MDLIVE for Cigna mobile app from your favorite app store today!

MDLIVE for Cigna®

Get started!

Visit the website to register:

- **www.MDLIVEforCigna.com**

Or call the below number:

- MDLIVE: 1-888-726-3171

Signing up is easy!

- Set up and create an account with MDLIVE.
- Complete a medical history using their "virtual clipboard."
- Download the MDLIVE for Cigna mobile app from your favorite app store today!

Cost

OAP HSA (HDHP)

Deductible, then PCP/Specialist copay*

* *Under the OAP HSA medical plan, telehealth services are subject to the deductible. When you are in the deductible phase, the cost per telehealth visit will be $55—much less than the PCP/Specialist contracted rate!*

Health Savings Account

You can set up an automatic per pay deposit to fund your HSA on a regular basis without any hassle. Your contributions will be deducted pre-tax from your pay and deposited into your Bank of America HSA.

The annual contribution limits set forth by the IRS for **2025** are:
Individual - **$ 4,300**
Family - **$ 8,550**

Individual account holders age 55 or older may contribute an additional $1,000 per year.

Available to employees who enroll in the OAP HSA (HDHP) plan

When you enroll in the OAP HSA (HDHP) medical plan, you are eligible to open a Health Savings Account (HSA). An HSA can help you save money by allowing you to pay for health care expenses with tax-free dollars. You can use the funds to pay for qualified health care expenses, such as medical and prescription drug expenses until you meet your deductible, coinsurance, copays, and other out-of-pocket expenses including dental and vision expenses, for you and your tax dependents*—even if they are not covered under your medical plan! To be eligible to open and contribute to an HSA, you must be enrolled in an HSA-qualified health plan and must not be covered by other health insurance that is not an HSA-qualified plan, including Medicare or a spouse's Health Care FSA.

**Dependents must be claimed on your tax return to be considered eligible to be reimbursed from the account. However, dependents do not have to be enrolled in the OAP HSA plan to use HSA dollars.*

Reasons to Love a Health Savings Account (HSA)

- Triple Tax Savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for health care expenses with tax-free money.
  - Whatever you don't use in a year rolls over to the next year, and earns interest that is tax-free!
- You decide how and when to use the funds in your account—you can use the funds to pay for your health care expenses or save them for future health care costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty (but will be taxed as ordinary income if funds are not used for qualified medical expenses).

HSA Highlights

Loyola has partnered with **Bank of America** to offer the HSA to employees. Each account is employee-owned and funded. There is a monthly maintenance fee of $2.50, which will be deducted directly from your account. The Bank of America HSA features:

- Easy access to your funds. Use your Bank of America Visa debit card to pay eligible costs at the doctor's office, pharmacy or wherever else Visa debit cards are accepted. Remember to keep your receipts in case they're needed by the IRS to verify eligible expenses.
- Easy tracking of health care costs. You can view balances and recent activity online at any time. All your expenditures will be reported in a single monthly statement.
- Investment options available after you have $1,000 in your account.
- Rollover funds from another HSA if you currently have an HSA.
- One-time trustee-to-trustee transfer from your Individual Retirement Account (IRA).
- Visit **http://healthaccounts.bankofamerica.com/learn-individuals.shtml#.WOvJMXfMzUI** to access resources and additional HSA education.

How the OAP HSA (HDHP) Medical Plan and HSA work together

Get preventive care at no cost to you

In-network preventive care is covered at 100% with no deductible. You pay $0 out-of-pocket for your annual physical, well woman visit, mammogram, colonoscopy, routine immunizations, preferred preventive drugs, and other eligible services.

Pay for other medical expenses

You pay for additional medical and prescription drug expenses as you incur them until your annual deductible is met.

Use your HSA

You can use the funds in your HSA to pay for qualified health care expenses, such as medical and prescription drug expenses, coinsurance, copays, and other out-of-pocket expenses including dental and vision expenses. Remember to save your receipts in case they are needed to verify eligible expenses!

What to do when you go to the doctor's office

When you go to the doctor's office, present your Cigna ID card and let them know that you have a high deductible health plan. The doctor's office will bill Cigna. Cigna will review the claim and apply discounted rates. The amount you owe will either be credited toward your deductible or paid to the provider per your benefit plan if you have already met your deductible.

You will receive an Explanation of Benefits (EOB) from Cigna. Check to make sure that the amount Cigna says you owe matches the bill you receive from the provider.

Once you receive a bill from the provider, pay it using your Bank of America HSA debit card. If the doctor's office doesn't accept credit cards you can pay out-of-pocket and reimburse yourself from your HSA.

What to do when you need a prescription

Present your Cigna ID card at the pharmacy. The pharmacy system processes in real-time so the pharmacy will be able to tell you exactly what you owe when you pick up your prescription. Pay your bill at the register using your Bank of America HSA debit card.

Need more information on HSAs?

Visit **https://www.brainshark.com/hilbgroup/Loyola-HSA101** to view the "HSA 101" presentation. Have a smartphone or tablet? Scan the QR code to view the presentation.

*A list of eligible expenses is available on the IRS website, **www.irs.gov**. Please consult your tax advisor should you require specific tax advice.*

Reminders:

- Be sure the bill from the provider matches the amount that Cigna says you owe.
- Keep your EOBs, invoices and receipts! It is your responsibility to provide this documentation if you get audited by the IRS.
- The HSA debit card will only work if there is money in the account.

Reasons to Love a Health Savings Account (HSA)

- Triple tax savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for health care expenses with tax-free money.
  - Whatever you don't use in a year rolls over to the next year, and earns interest that is tax-free!
- You decide how and when to use the funds in your account—you can use the funds to pay for your health care expenses or save them for future health care costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty (but will be taxed as ordinary income if funds are not used for qualified medical expenses).

Sick Leave—Temporary Staff and Administrators

Sick leave is paid leave granted on the terms described in this policy to employees who are absent from work due to illness, injury, impairment, medical or dental appointments. Sick leave may be taken for the following reasons:

- Care or treatment of the employee's or a family member's mental or physical illness, injury, or conditions;
- Preventive medical care for the employee or family member;
- Maternity or paternity leave; and
- Absences that are necessary due to domestic violence, sexual assault, or stalking committed against the employee or the employee's family member, including obtaining medical or mental health attention, victim services, or legal assistance.

Family member means an employee's child, spouse, parent, parent-in-law, siblings, grandchildren and grandparents. Biological, adopted, foster, step and in "loco parentis" (when someone stands in the place of a parent) relationships are recognized.

Eligibility

Sick leave begins to accrue on the first day of employment. Direct hire temporary employees are eligible for sick leave after 106 calendar days of employment. A supervisor/department chair may require that an employee provide verification of the need for leave if an employee uses the leave for more than two consecutive shifts. Leave may be taken in one minute increments as established by the University. For additional information, contact the benefits and wellness unit (ext. 1365).

Notifying Your Supervisor/Department Chair

An employee who wishes to take sick leave for a reason set forth above must contact the employee's supervisor/department chair at or before the beginning of the workday on each day of absence. Employees must use the telephone number or method specified by the employee's supervisor/department chair for this purpose. Failure to keep a supervisor/department chair informed of your absence for three consecutive days may be considered job abandonment, unless circumstances made it impossible to communicate with the supervisor/department chair. If the need for leave is foreseeable, such as to attend a pre-scheduled doctor's appointment, the employee must provide at least seven days' notice of the leave, where possible. Sick leave hours must be reported in the electronic time keeping system.

Computing Sick Leave Accrual

Temporary employees who work over 24 hours in a pay period accrue sick leave at a rate of one hour for every 30 hours worked. Sick leave is not included in the calculation of hours worked for overtime purposes. The University provides notice to eligible employees of the amount of sick leave that is available for use via Loyola earnings statements.

Direct hire temporary employees are not entitled to earn more than 40 hours of sick leave in a year (July 1–June 30) or accrue more than 64 hours of earned sick leave at any time. Once the maximum amount of hours is accrued, sick leave hours are not added until the accumulated balance falls below 64 hours. Sick leave automatically stops accruing once the balance has reached the maximum hours allowed. Sick leave accrual is suspended during periods of unpaid leave. No payment will be made for unused sick leave upon separation of employment. If an employee leaves employment and is rehired within 37 weeks of leaving, any earned and unused sick leave that the employee had at the time of separation will be reinstated, up to a maximum of eight days.

Direct Hire Temporary Employees	
Completed years of service	Begins date of hire
Hours accumulated per pay	1 hour for every 30 hours worked
Maximum hours allowed	40 in a benefit year, or up to 64 if unused accruals carry to the next benefit year

Notice Regarding Maryland Healthy Working Families Act

The Maryland Healthy Working Families Act (the "Act") requires Maryland businesses with at least fifteen (15) employees to provide paid sick leave to employees who regularly work twelve (12) or more hours each week. The sick leave may be used for the reasons set forth above. The University's sick leave accrual rate and accumulation maximum cap for regular employees exceeds the Act's requirement that employers provide up to forty (40) hours of sick leave per benefit year (July 1 to June 30 each year) for full-time employees, accrued at a rate of one (1) hour of leave for every thirty (30) hours worked. While the University's sick leave accrual rate and accumulation maximum cap for regular employees exceeds the Act's requirements, only the employee's first forty (40) hours of sick leave per benefit year will be considered "sick and safe leave" subject to the Act (or sixty four (64) hours if the employee has carried over unused "sick and safe leave"). The University's sick leave accrual rate and maximum cap for temporary employees is at the requirement for the Act. Maryland law prohibits an employer from taking an adverse action against an employee who exercises a right under the Act. Employees may report alleged violations of the Act to the Maryland Commissioner of Labor and may bring a civil action to enforce an order of the commissioner. Employees may not make a complaint, bring an action, or testify in bad faith before the Commissioner. Employees found to have done so are subject to a misdemeanor and fine not exceeding $1,000.

Required Notices

Women's Health and Cancer Rights Act of 1998

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). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for medical and surgical benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices for the medical plan and health care Flexible Spending Account is available from Human Resources. A copy of the Privacy Practices is available from the insurance carriers for dental and vision insurance.

Newborns' and Mothers' Health Protection Act

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 caesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) because of other health insurance or other 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 toward your or your dependents' coverage). However, you must request enrollment within 30 days after your previous 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 in this plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Wellness Program—Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, your personal information will never be disclosed (either publicly or to the employer), except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. You will not be discriminated against in employment because of medical information you provide as part of participating in the wellness program, nor will you be subject to retaliation if you choose not to participate.

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, 2021. Contact your State for more information on eligibility.

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

To see if any other states have added a premium assistance program since January 31, 2021, 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

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance was introduced: 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.

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. 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.

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 Benefits & Wellness Unit at Loyola University.

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Loyola University has determined that the prescription drug coverage offered by Loyola University, 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 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage with Loyola University will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your medical and prescription drug coverage through Loyola University, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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 Loyola University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed on this notice 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 Loyola University changes. You also may request a copy of this notice at any time.

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	July 1, 2025
Sender:	Loyola University
Contact:	Benefits & Wellness Unit
Address:	4501 North Charles Street Baltimore, MD 21210
Phone:	410-617-1365

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance was introduced: 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.

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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.

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. 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.

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 Benefits & Wellness Unit at Loyola University.

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

Women's Health and Cancer Rights Act of 1998

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). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for medical and surgical benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices for the medical plan and health care Flexible Spending Account is available from Human Resources. A copy of the Privacy Practices is available from the insurance carriers for dental and vision insurance.

Newborns' and Mothers' Health Protection Act

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 caesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) because of other health insurance or other 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 toward your or your dependents' coverage). However, you must request enrollment within 30 days after your previous 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 in this plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Wellness Program—Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, your personal information will never be disclosed (either publicly or to the employer), except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. You will not be discriminated against in employment because of medical information you provide as part of participating in the wellness program, nor will you be subject to retaliation if you choose not to participate.

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: **myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: **myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid
Website: **myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA — Medicaid
Website: Health Insurance Premium Payment (HIPP) Program **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+) Health First Colorado Website: **www.healthfirstcolorado.com/**
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: **hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): **www.mycohibi.com/** HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: **www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA — Medicaid
GA HIPP Website: **medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: **www.in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid
Website: **www.in.gov/medicaid/**
Phone 1-800-457-4584

IOWA — Medicaid and CHIP (Hawki)
Medicaid Website: **dhs.iowa.gov/ime/members** Medicaid
Phone: 1-800-338-8366
Hawki Website: **dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: **www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **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: **chfs.ky.gov/ agencies/dms**

LOUISIANA – Medicaid
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: **www.mymaineconnection.gov/benefits/s/?language=e n_US**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: **www.maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: **www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Website: **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

MISSOURI –
Medicaid Website: **www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid
Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: 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
Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid
Website: www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON - Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP
Website: 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)

RHODE ISLAND - Medicaid and CHIP
Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA - Medicaid
Website: www.scdhhs.gov/
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: dss.sd.gov/
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP
Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT - Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
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
Website: www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: dhhr.wv.gov/bms/mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP
Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website:
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, 2025 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.

Resources

Who to contact when you have questions about your benefits

If you have any questions about your benefits you may contact Loyola's Benefits & Wellness Unit, the insurance carrier, or PSA Insurance & Financial Services. PSA is a consulting firm chosen by Loyola to assist with the administration and selection of your benefit plans. PSA can be reached at **1-877-716-6618** or via email at **loyola@psafinancial.com**.

Plan	Phone Number	Website
Medical Cigna	1-800-244-6224	**www.cigna.com**
Pharmacy Cigna	1-800-244-6224	**www.cigna.com**
Health Savings Account Bank of America	1-866-791-0250	**www.bankofamerica.com**
Loyola HR, Benefits & Wellness Unit	410-617-1365	**www.loyola.edu/department/hr/benefits**
Benefit questions, eligibility, claims issues PSA Insurance & Financial Services	1-877-716-6618	Email: **loyola@psafinancial.com**

This communication highlights some of the benefit plans available. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the official plan documents will always govern. The University reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

PSA
A Hilb Group Company