SHERMAN COLLEGE *of* CHIROPRACTIC

Employee Benefits Guide

Medical | Dental | Vision | Life | Disability

2026

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. Sherman College has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical			
Planned Administrators Incorporated (PAI)	581	www.PAISC.com	800-768-4375
Prescription			
Planned Administrators Incorporated (PAI)		www.PAISC.com	855-260-0974
Flexible Spending Accounts			
Flores		www.flores247.com	888-722-8382
Dental			
Mutual of Omaha	G000AW35	www.mutualofomaha.com	800-769-7159
Vision			
Eyemed	9955428	www.eyemedvisioncare.com	866-939-3633
Basic Life and AD&D Insurance **Voluntary Life Insurance**			
Mutual of Omaha	G000AW35	www.mutualofomaha.com	800-769-7159
Short-Term Disability **Long-Term Disability** **Voluntary Critical Illness Insurance**			
Mutual of Omaha	G000AW35	www.mutualofomaha.com	800-769-7159
403(b) Retirement Plan			
TIAA-CREF		www.tiaa-cref.org/myretirementplan	800-842-2252
Employee Assistance Program (EAP)			
Mutual of Omaha		www.mutualofomaha.com/eap	800-316-2796
Sherman College HR			
Mandy Smith		msmith@sherman.edu	864-578-8770, ext 231
Christy Potts		cpotts1@sherman.edu	864-578-8770, ext 393
Sherman College Benefits Helpline			
Angela Montgomery		Angela.Montgomery@assuredpartners.com	864-772-3120

New Educational Video Library!

Check out our new educational video library designed to help you navigate the world of insurance with ease. This library features a collection of short, informative videos covering a wide range of insurance-related topics. Dive in and empower yourself with the knowledge to make informed decisions about your benefits!

Find links to individual videos throughout this guide, or check out the full library by clicking this box.

Your employer may not offer all benefits shown in video library.

Welcome to your 2026 Employee Benefits!

Sherman College of Chiropractic takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

SHERMAN COLLEGE *of* CHIROPRACTIC

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Sherman College reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How to Enroll

Paycom's Employee Self-Service

Enrolling in benefits is simple through Paycom's Employee Self-Service feature. To access, go to:

www.paycom.com

Then select "**Employee**." Enter your username, password and the last four digits of your Social Security number. Then select "**Log in**."

The enrollment process will be broken down into 5 steps:

- **Enter Personal Contact Information** - First, you will be directed to enter your personal contact information. After this, you will choose to enroll or decline your company's benefit plans.
- **Dependents and Beneficiaries** - Some of the plans you choose to enroll in, such as life insurance, may require beneficiaries. Enroll in the plan just as you would any other plan.

  Dependents who have already been added will appear as an option to include as beneficiaries. When finished, click "Save and Next."
- **Quick Enrollment** - Then you will be directed to the Quick Enrollment screen. From here, you're asked to select which benefits you would like to view or you can decline benefits from this screen. Once all of the benefits you would like to view have been selected, click "Next."

  You will be guided through the enrollment process for each of your available benefit plans. Each benefit screen will have two check boxes: one to enroll and one to decline. If there are forms or links attached to this plan, they will be located in "Plan Documents." Check the box to enroll or decline coverage for this plan. Then, click "Enroll."
- **Review** - Finally, you can click "Review" to see all the benefits you've chosen to enroll in at a glance.
- **Finalize Your Selections** - Once you are satisfied with your selections, click "Finalize." A pop-up window will ask you to confirm if you want to complete enrollment.

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective the exact date of hire, the next month. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate; however, Part Time employees are eligible for the retirement plan.

Eligible Dependents

Your dependents are eligible to participate in Sherman College's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired / Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage as well as to provide beneficiary information for your company-paid life insurance.

For all benefits except the Voluntary Life and 403(b) Retirement Plan, you must enroll within 30 days from your date of hire by going to www.paycom.com.

Pre-Tax Benefits: Section 125

Sherman College's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

You must notify Sherman College's Human Resources Department within 30 days from the life event status change in order to make a change in your benefit selections.

Working Spouse Rule

Our health care plans have the **"Working Spouse Rule,"** which means that if your spouse is employed, and his or her employer contributes to the cost of medical coverage, your spouse **MUST** be enrolled for at least individual coverage in their company's plan in order to be covered on a secondary basis under our medical plan.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate must be presented. Once you receive the child's Social Security Number, be sure to contact Human Resources to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to HR. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can contact Mandy Smith at msmith@sherman.edu or call 864-578-8770, ext 231.

Watch a brief video on changing your elections following life events.

Medical Coverage

Sherman College is proud to offer you a choice between two different medical plans. Coverage under both plans includes comprehensive medical care and prescription drug coverage. These plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

PPO Plans

Both the **Premium PPO and Basic PPO plans** are Preferred Provider Organization (PPO) which offers you the freedom to receive care from any provider—in or out of your network. This means you can see any doctor or specialist, or use any hospital.

In addition, PPO plans do not require you to choose a Primary Care Physician (PCP) and do not require referrals. For example, if you already have a doctor you like, you can continue receiving care from that provider.

If you need to see a specialist, you do not have to first consult with a PCP. No referrals are required for any doctor, specialist or hospital.

A traditional medical plan offers first dollar copays for office visits and prescription drugs. While larger medical expenses go towards your deductible and coinsurance.

Out-of-Network Providers

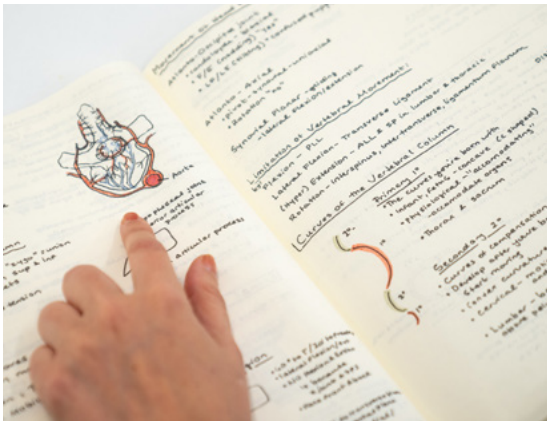
You may choose to seek care outside the PAI network without a referral, however you will pay a higher deductible and coinsurance for care received from an out-of-network physician, facility or other health care professional. In addition, PAI only pays a portion of those charges and it is your responsibility to pay the remainder if you choose to seek care outside the network. The amount you are required to pay, which could be significant, contributes to a separate out-of-network out-of-pocket maximum. It's recommended that you ask the out-of-network physician or health care professional about their billed charges before you receive care.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

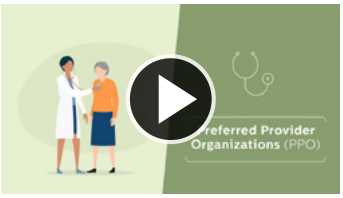
The BlueCross BlueShield Preferred Blue Network is the PPO for this Group Health Plan. Outside of your primary service area, employees will use First Health as the PPO.

For assistance locating a First Health Provider, call 1-800-226-5116 or visit **www.myfirsthealth.com**.



Build a Strong Relationship with Your Primary Care Physician

1. **Personalized Care:** A good relationship allows your PCP to understand your medical history, lifestyle, and preferences, leading to more tailored and effective healthcare.
2. **Trust and Communication:** Trust fosters open communication, making it easier to discuss sensitive issues and follow medical advice.
3. **Preventive Health:** Regular visits and a strong rapport can help in early detection and prevention of health issues.
4. **Coordination of Care:** Your PCP can coordinate with specialists and manage your overall healthcare plan, ensuring continuity and comprehensive care.
5. **Mental Health Support:** A trusted PCP can provide support for mental health concerns, offering guidance and referrals when needed.



Watch a brief video on how Preferred Provider Organizations work.

Medical Plan Comparison

	Premium PPO In-Network, You Pay:	Basic PPO In-Network, You Pay:
Annual Deductible Individual / Family	**$1,500 / $3,000**	**$2,000 / $4,000**
Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000	$8,000 / $16,000
Preventive Care	100% covered	100% covered
Office Visits Primary Care Physician Specialist	 $30 copay $30 copay	 $30 copay $30 copay
Urgent Care	$30 copay	$30 copay
Emergency Room Care	$500 copay	$500 copay
Inpatient & Outpatient Hospital Services	Deductible, then 30%	Deductible, then 40%
Retail Prescriptions (30-day supply) Generic Brand Preferred Non-Preferred Brand Specialty	 $15 copay $70 copay $70 copay 30%	 $15 copay $70 copay $70 copay 30%
Mail Order Prescriptions (90-day supply) Generic Brand Preferred Non-Preferred Brand Specialty	 $37.50 copay $175 copay $175 copay 30%	 $37.50 copay $175 copay $175 copay 30%
	Out-of-Network, You Pay:	**Out-of-Network, You Pay:**
Out-of-Net. Deductible (Individual / Family)	$1,500 / $3,000	$2,000 / $4,000
Out-of-Net. Out-of-Pocket Max (Individual / Family)	$7,000 / $14,000	$8,000 / $16,000
Co-insurance amount you pay for most services	Deductible, then 50%	Deductible, then 60%

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay (24 pay periods)	Premium PPO	Basic PPO
Employee Only	$90.00	$62.50
Employee + Child	$222.50	$195.00
Family	$325.00	$260.00

Tobacco Users: Add $100 per month to the employee rate if the employee or any insured dependent uses a tobacco product.

Telemedicine and Virtual Counseling from PAI

You now have 24/7 access to doctors and counselors via phone or video with telemedicine and virtual counseling. Both services are provided to employees and their immediate family for free.

Get treatment within minutes for minor injuries, illnesses, prescriptions and short-term counseling.

- Cough & Sore Throat
- Infection (Sinus, Ear, UTI, etc.)
- Skin Rash
- Muscle/Joint Pain
- Medication Refill
- Anxiety
- Depression
- Marital/Relationship
- Substance Use
- Work/Life Stress

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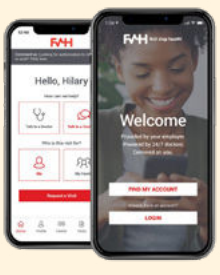


PAI Portal Registration

***IMPORTANT NOTES when registering:**

- If a middle initial appears on your Member ID card, include it in the First Name field of the registration form, as shown below.
- If a period (.) appears on your Member ID card after the middle initial, be sure to include it. If no period (.) is present, be sure not to add one.
- If a comma (,) appears on your Member ID card after the last name and before the suffix, be sure to include it. If no period (,) is present, be sure not to add one.
- If a suffix appears, such as Jr. or Sr., add it in the Last Name field.
- If a period (.) appears on your Member ID card after the suffix be sure to include it. If no period (.) is present, be sure not to add one. Exact names are required. For example, if John is your first name, but you go by Jack, John will be required in the First Name field.

Access the member portal at paisc.com/members. For plan questions, call the phone number listed on your ID card.

myBenefitsManager Member Portal

- View your plan document and benefit summaries
- Print, view, request an ID card, or download a PDF version to share
- Find a network health care provider
- Access your claims and explanation of benefits
- View current deductible and out of pocket balances
- Access your pharmacy benefits
- View member discounts and value-add programs

Registration

1. Visit MyBenefitsManager Member Login at **PAISC.COM**.
2. Click on **Select your portal** and choose **Member Portal**.
3. Click on Create account, accept the license agreement, click Next, and follow the prompts. **Enter your name exactly as shown on your member ID card.**

   For security, a new account is required and a two-step authentication process has been added. Your Member ID Number is on your ID Card.
4. Once completed, an email is sent confirming success of the sign up process.

Logging In

Once you have registered for the Member Portal, you may use your username and password to sign in. The Sign In button is on the Member Portal home screen.

Once logged in to the Home page, you can see dashboards containing your coverage summary, claim information and Quick Links.

pai
We make Benefits Better.

Dental Coverage

Mutual of Omaha Dental DPPO

The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at www.mutualofomaha.com, or by calling 800-769-7159.

	Dental DPPO	
	In-Network You Pay	Out-of-Network, You Pay*
Calendar Year Maximum	$1,500 per person	$1,500 per person
Calendar Year Deductible Per Individual / Per Family	$50 / $150	$50 / $150
Type A Services - Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	100% covered	100% covered
Type B Services - Basic Restorative Care Fillings, Simple Extractions, Anesthetics, Root Canal Therapy, Repairs (Bridges, Crowns, Inlays and Dentures)	Deductible, then 20%	Deductible, then 20%
Type C Services - Major Restorative Care Crowns, Inlays, Onlays, Dentures, Bridges, Stainless Steel/ Resin Crowns	Deductible, then 50%	Deductible, then 50%
Orthodontia Coverage for Children & Adults	50%, No Ortho Deductible	50%, No Ortho Deductible
Orthodontia Lifetime Maximum	$1,500	$1,500

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Late Entrants for Dental:

Persons who request coverage more than 31 days after their original eligibility date are considered late entrants. Preventive services are covered in the first 12 months. Basic, Major & Orthodontics are available after 12 months.

***Out-of-Network Providers & Balance Billing**

Under the Dental PPO, the plan pays the same amount to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

Plan Cost Per Pay (24 pay periods)	Dental Plan
Employee Only	$8.00
Family	$23.25

Mutual of Omaha

View dental benefits & claims

- Log on to mutualofomaha.com/dental
- Click on "my dental benefits"
- Click the "register" button then enter your name, member ID number (located on your member ID card) and follow the instructions to select your username and password

Logging on

- Go to mutualofomaha.com/dental
- Enter username & password
- Click the "log in" button

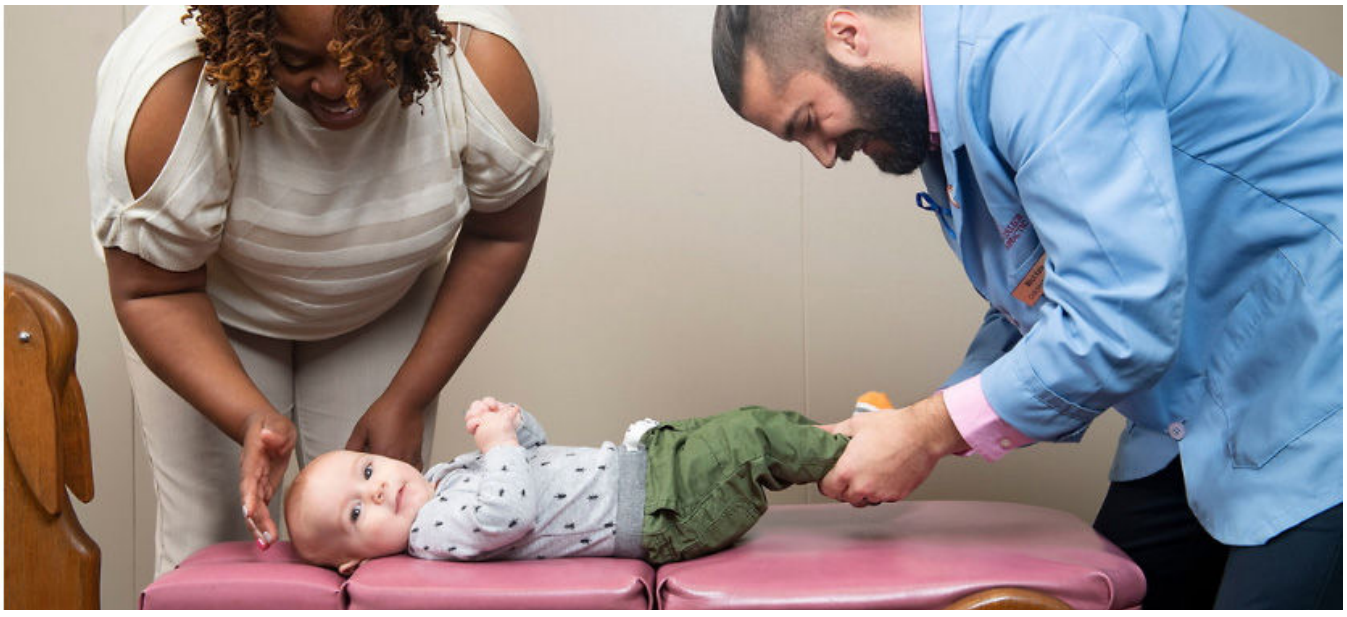
Vision Coverage

Eye Med Vision Plan

As a vision care member, you'll receive access to great eye doctors, quality eyewear and lower out-of-pocket costs. To find an in network provider, visit www.eyemedvisioncare.com or call 866-939-3633.

Plan Cost Per Pay (24 pay periods)	Vision Plan
Employee Only	$2.50
Employee + 1	$3.75
Family	$7.50

Benefit	In-Network	Out-of-Network Reimbursement	Frequency
Exam Copay	$10 copay	N/A	12 months
Exam Allowance (One per frequency period)	100% after copay	Up to $40	12 months
Frame Allowance			
(One per frequency period)	Up to $130; 20% off remaining balance	Up to $91	24 months
Eyeglass Lenses Allowance (One pair per frequency period)			
Single Vision	$25 copay	Up to $30	12 months
Lined Bifocal Lens	$25 copay	Up to $50	12 months
Lined Trifocal Lens	$25 copay	Up to $70	12 months
Standard Progressive Lens	$90 copay	Up to $50	12 months
Premium Progressive Lens	$110 - $135 copay	Up to $50 - $70	12 months
Lenticular Lens	$25 copay	Up to $70	12 months
Contact Lenses Allowance (One pair per frequency period)			
Conventional / Disposable	$0 copay, $130 allowance	Up to $130	12 months
Medically Necessary	$0 copay, 100% covered	Up to $210	12 months



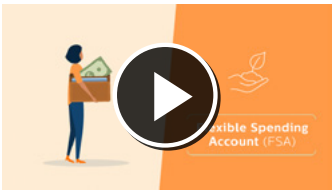
Flexible Spending Accounts

What is an FSA?

A Flexible Spending Account (FSA) is a tax-advantaged account provided by employers that allows employees to use pre-tax dollars to pay for qualified medical expenses or dependent care.

To qualify for an FSA, you do not need to be enrolled in a Sherman College's medical plan. You must enroll during open enrollment or within a special enrollment period if you experience a qualifying life event.

Flexible Spending Account Options		Contribution Limit
Health Care FSA	**HSA Participants are Not Eligible:** Federal regulations do not allow participation in an HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more. **For the 2026 plan you will be able to rollover up to $680.**	**$3,400 per year**
Dependent Care FSA	You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers. **Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.**	**$5,000 per year** *(Or $2,500 if you are married and file a separate tax return.)*



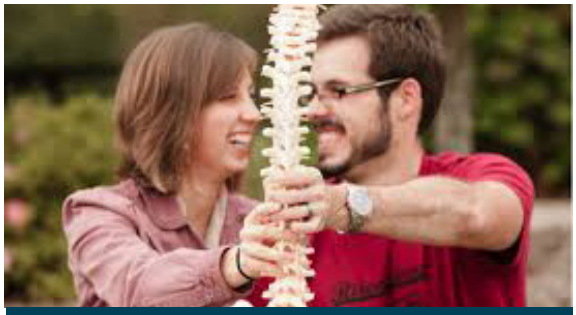
Watch a brief video on Flexible Spending Accounts (FSAs).

Watch a brief video comparing HSAs and FSAs.

The FSA Plan Year is January 1 until December 31. "Use it or Lose it" FSA Rule:

Consider your expenses carefully before you decide how much to contribute to each FSA account. If your eligible expenses for the calendar year turn out to be less than the amount contributed to your FSA account, **federal law requires that the unused balance in excess of the allowed rollover be forfeited** (the "Use it or Lose it" rule). As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

Basic Life | AD&D Insurance



Plan Cost: 100% Employer Paid

Basic Life Insurance

Life insurance provides financial protection for your family in the event of your passing. Sherman College offers all employees life and accidental death and dismemberment insurance through Mutual of Omaha. If you elect dependent medical coverage, you will also be enrolled for dependent life insurance. Sherman College covers the full cost of this benefit. Late applicants are subject to evidence of insurability, and can be denied coverage.

Basic Life Benefit Amount: Employee - $50,000
Spouse - $5,000
Dependent Children 14 days+ - $5,000

AD&D Benefit Amount: Equal to Life amount

Your benefit amount will reduce by 65% at age 65; 50% at age 70. Benefits terminate upon retirement.

Voluntary Life Insurance

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Mutual of Omaha. This coverage comes in the following increments:

Voluntary Life Insurance

	Employee	Spousal	Dependent Child
Benefit Amount	increments of $10,000	increments of $10,000	increments of $5,000
Guaranteed Issue	the lesser of 5x Annual Base Earnings or $100,000	$10,000	$10,000
Maximum Benefit	5x Annual Base Earnings rounded to next higher multiple of $10,000	$100,000	$10,000

Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit. Child amount cannot exceed spouse amount.

Your benefit amount will reduce by 65% at age 70; 45% at age 75; 30% at age 80; 20% at age 85; 15% at age 90. Benefits terminate upon retirement.

If you enrolled in the minimum amount of voluntary life coverage during your initial enrollment, you can increase your coverage by $10,000 at open enrollment without answering evidence of insurability questions.

Portability Options for Voluntary Life and Conversion Options for Basic Life

Portability or conversion are available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact HR

Disability

Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability that extends for more than 14 consecutive days, Sherman College provides short-term disability (STD) through the Mutual of Omaha. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After:	14 days
Benefit Amount:	60% of basic earnings
Maximum Benefit:	$750 / week
Benefit Duration:	11 weeks
Plan Cost:	**100% Employer Paid**

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

Benefits Start After:	90 days
Benefit Amount:	60% of predisability monthly earnings
Maximum Benefit:	$10,000 / month
Benefit Duration:	The later of your SSNRA* or the Maximum Benefit Period.
Plan Cost:	**100% Employer Paid**

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Watch a brief video on Disability Insurance and how it works.

Need to take extended leave? Watch a brief video on FMLA leave.

Voluntary Critical Illness

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

You have the choice of electing coverage of $10,000 or $20,000.

Both amounts are 100% Guaranteed Issue coverage, your spouse will be offered 100% of your benefit amount, and child(ren) will be offered 25% of your benefit amount. Child dependent coverage is offered at no additional cost.

When you turn age 70,the original amount of insurance will reduce to 50% for both you and your spouse.

Coverage includes:

Benefit Amount pays 100%, unless otherwise noted

- Heart Attack (Myocardial Infarction)
- Coronary Artery Bypass *(Benefit Amount pays 25%)*
- Stroke
- Major Organ Transplant/Placement on UNOS List
- End-Stage Renal Failure
- Cancer (Invasive)
- Bone Marrow Transplant
- Carcinoma in Situ *(Benefit Amount pays 25%)*
- Advanced Alzheimer's Disease (payable once per insured person under the policy)

Employee Assistance Program

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. Mutual of Omaha's Employee Assistance Program (EAP) is a company-sponsored service that is available to you and your dependents, at **NO COST** to you, to provide confidential support, resources and information to get through life's challenges.

Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. The EAP staff members are all licensed, master's level Employee Assistance Professionals. They provide a solution-focused approach by assessing your situation and referring to the appropriate resources necessary. When you call, you will speak directly to an EAP professional to receive immediate support and guidance.

You can entrust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner.

Our goal is to collaborate with you and find solutions that are responsive to your needs. If additional resources are needed, your EAP professional can assist by locating affordable solutions in your area.

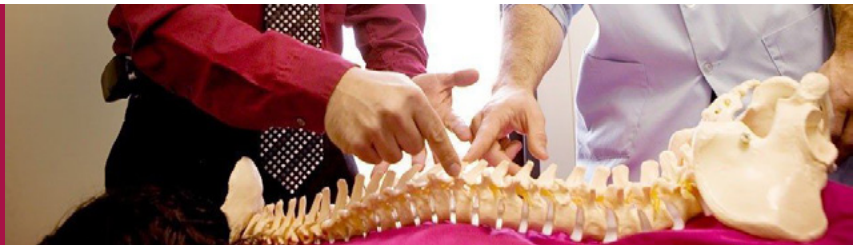
Call any time with personal concerns, including:

- Emotional well-being
- Healthy lifestyles
- Family and relationships
- Work and life transitions
- Legal and financial

Additional EAP benefits include:

- Information and referral services
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap
- Online Resources for Substance use and Dependent and Elder Care resources
- Legal library and online forms
- Financial assessment and online tools

Access to EAP professionals 24 hours a day, seven days a week at 800-316-2796 or visit mutualofomaha.com/eap



SHERMAN COLLEGE *of* CHIROPRACTIC

AssuredExcellence™

Plan Enhancement!

Specialty Medications at **no cost!**

PRICEMDs
Cost Containment Solutions™

Sherman College has partnered with PriceMDs to provide you with a source of specialty medications at no cost!
No travel required, no copays, just free meds!

Are you currently taking specialty medications for a disease or chronic condition? Examples include medications for crohn's disease, ulcerative colitis, rheumatoid arthritis, multiple sclerosis, or a variety of other conditions.

AssuredExcellence, your source for no-cost surgeries and transplants can now assist in sourcing no-cost medications.

You will receive a stipend payment for your first fill of a 90-day supply!

$1,000 *on medications >$10,000...*

or ***$500*** *on medications $3,000–$9,999...*

or ***$250*** *on medications <$3,000.*

- Over 600 medications available and counting.
- Two fills required before engaging with PriceMDs.
- Members that qualify will be connected with a PriceMDs nurse.
- No change in your physician required!
- You may be required to do a tele-health visit with a US-trained and board-certified doctor.
- PriceMDs may require your doctor to submit lab results, or have you get bloodwork done.
- Once approved the PriceMDs nurse will arrange shipping of 90-day supply of meds direct to you!
- Member participation requires REAL ID or a valid passport. No travel required.

If you are enrolled in a Qualified High Deductible Health Plan, you may be subject to charges at the end of the plan year.

If you're on specialty medications and want to find out if your medication is covered, contact an AssuredExcellence representative today!

(888) 856-4317 AssuredExcellence@AssuredPartners.com

AssuredExcellence™

Low to No Cost Access to Leading National Providers

Sherman College has partnered with **the AssuredExcellence program** to connect you and your dependents[1] with ***high quality health care at minimal to no cost.***[2] The program includes benefits for a broad range of services such as:

- ✓ Orthopedic Procedures
- ✓ Cardiac Surgeries
- ✓ Cancer Diagnosis Confirmation Program
- ✓ Some Cancer Procedures
- ✓ Organ Transplant
- ✓ Gallbladder Surgery
- ✓ Eating Disorder Services
- ✓ Hernia Surgery
- ✓ Outpatient Mental Health Treatment
- ✓ Inpatient Substance Abuse Treatment
- ✓ High-Cost Medications
- ✓ Pediatric Orthopedics
- ✓ Other Treatments are Available

How can I begin the process?

Call the AssuredExcellence team to check eligibility.

Complete an application; provider will review.

Provider will gather and review medical records.

Consultation, surgery, or services are scheduled.

A stipend is paid to you to assist with lodging & transportation.

If you are interested in learning more about the program, checking to see if it includes benefits for the services you need and/or receiving an application, please contact AssuredExcellence at **888-856-4317** or via e-mail at **AssuredExcellence@AssuredPartners.com**.

[1] *Patients must be over age 18 for certain services.*

[2] *Employees enrolled in a high deductible/HSA Qualified Plan will be responsible for the balance required to meet the IRS minimum deductible. There is no patient liability for covered services for all other program participants.*

To ensure that you receive the maximum benefits available you MUST contact the AssuredExcellence team to initiate the process.

1-888-856-4317 | AssuredExcellence@AssuredPartners.com

Participating Partners:

- carrum health
- Cleveland Clinic
- Eating Recovery Center
- Pathlight Mood & Anxiety Center
- GOLDFINCH Health
- Hazelden Betty Ford Foundation
- Hoag Orthopedic Institute
- JOHNS HOPKINS MEDICINE
- MIDLANDS orthopaedics & NEUROSURGERY
- MIDWEST ORTHOPAEDICS AT RUSH — A division of OrthoMidwest®
- PRICEMDs Cost Containment Solutions™
- Shriners Children's™

Why is this program being offered?

The health and well being of our employees and their families is of paramount importance, and we feel strongly about helping you get care at the best facilities across the country.

How much does it cost?

For most health plans, all treatments at these providers will be at ***NO COST*** to you. Diagnostic procedures required prior to your treatment will go through your regular insurance.

Do I have to travel?

You may, but there are stipends built into the program that are generally enough to cover your travel and more.

Please contact the AssuredExcellence team to discuss any questions or concerns you may have and/or to receive an application to initiate the process.

AssuredExcellence™

Procedure Group	Travel Stipend
Bladder Cancer Surgery	up to $3,500
Bone Marrow Transplant	up to $5,500
Cancer Diagnosis Confirmation	up to $1,250
Some Cancer Surgeries (not all types are covered)	up to $3,500
Cardiac/Heart Surgery	up to $3,500
Colorectal Cancer Surgery	up to $3,500
Gall Bladder Surgery	up to $2,500
Organ Transplant	up to $5,500
Lymph Node Surgery	up to $2500
Neck and Spine Surgery	up to $2500
Orthopedic Surgery	up to $2500
Pancreatic Cancer Surgery	up to $3,500
Prostate Cancer Surgery	up to $2,500
Stem Cell Transplant	up to $5,500
Substance Abuse/Rehab	100% of bundled cost
Thyroid Surgery	up to $3,000
RA / PA Medications	Not Needed
Crohns / UC Medications	Not Needed
Multiple Sclerosis Medications	Not Needed
Rare Disorder / Specialty Medications	Up to $1,000 for first fill only

Travel stipend is determined by the necessary procedure and the AssuredExcellence provider you choose.

To find out what reimbursement you might be eligible to receive, please call AssuredExcellence.

Not every participating provider offers all the AssuredExcellence services. *9.24*

AssuredPartners does not recommend, endorse or make any representation about the efficacy, appropriateness or suitability of any specific tests, products, procedures, treatments, services, opinions, health care providers or other information that may be contained on or available through AssuredExcellence.

AssuredPartners
A Gallagher Company

1-888-856-4317

AssuredExcellence@AssuredPartners.com

Will Preparation Services

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die.

Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

That's why it's good you have access to FREE online will preparation services provided by Epoq, Inc. (Epoq).

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to **www.willprepservices.com** and use the code **MUTUALWILLS** to register
- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Mutual of Omaha

403(b) Retirement Plan

403(b) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

Eligibility

Tax Deferred Annuity - Available for employee contributions only and participation is optional. Employees opting to participate are eligible immediately.

Defined Contribution - Restricted to contributions made by the College. After completing one year of qualifying service, the Employee becomes eligible to participate. A summary plan description of this retirement plan is provided to all employees at the time of initial eligibility.

Roth retirement plan option – available for employee contributions to a Roth account after paying current income taxes on the money you contribute. You can withdraw the balance and any earnings tax free if certain conditions are met and must generally be age 59 ½ or older and leave the money in your designated Roth account for at least five years. There are no income restrictions. Roth retirement plans are capped at a higher contribution limit than Roth IRAs.

Employee Contributions

Contributions (Roth and pretax) combination basis from your compensation – up to the IRS annual limit of $24,500*. If you are 50 years of age or older (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

Employer Contributions

After completing one year of qualifying service, the employee becomes eligible for employer contribution. You must work at least 1,000 service hours during the plan year. Sherman college will make contributions as follows:

Completed Years of Service	% of Gross Salary
Less than 5 years	2%
5 years but less than 10 years	4%
10 years or more	6%
15 years or more	8%

Vesting

Completed Years of Service	Vested Percentage	Completed Years of Service	Vested Percentage
2	25%	4	75%
3	50%	5	100%

If you need assistance with enrolling online,
call TIAA-CREF at 800-842-2252
Monday through Friday, 8 am to 10 pm,
and Saturday, 9 am to 6 pm (ET).

**Projected. Limits are set by the IRS and subject to change.*

To Enroll Online

1 Go to
www.tiaa-cref.org/myretirementplan

2 Enter your access code:
#365077 and click **"Submit"**

3 Select your plan name and click **"Enroll Now."** Next, click the plan name under the **"Online Enrollment"** section.

Once on the "Welcome" page:

- Enter your User ID and click **"Log In"** if you have an established TIAA-CREF User ID and Password. Click "Register with TIAA-CREF" if you are a first-time user and need to create your User ID and Password.
- Follow the on-screen directions to complete your enrollment application.
- Note: At the allocation screen, click on any investment choice to view its fact sheet.
- Next, print a confirmation page from the "Thank You" screen.

You're eligible to receive retirement plan investment advice and education at **no additional cost**.

To schedule a session:

Visit **TIAA.org/schedulenow**

Call 800-732-8353, weekdays
8 am to 8 pm (ET) | 7 am to 7 pm (CT)
6 am to 6 pm (MT) | 5 am to 5 pm (PT)

Watch a brief video explaining 401(k) retirement plans.

FAQs

IT Issues

Why can't I login into my benefits?

It's recommended that you login using a desktop or laptop computer instead of a mobile device. Click the weblink in your guide or **TYPE the EXACT URL** into your top browser bar. Do not type into Google search bar.

How can I tell if my computer has the Minimal Requirements?

If your computer has the latest browser updates you should be able to login. For most computers you can find the version being used by going to "Help > About" menu selection.

ID Cards

How do I get ID cards for my plans?

If you do not have an ID card, contact the carrier to order your ID card or go online to the carrier's website to download an ID card.

I have not received my member ID card but need to see my doctor. What should I do?

For most plans, you can go to your Carrier's website to view a digital version of your member ID card.

If you are unable to view on the Carrier's website, then contact your Benefit Helpline or HR Department. If your application has been processed they will be able to give you your unique member ID number.

Preventive Care

What is considered preventive care and 100% covered at no cost?

Medical services that defend against health emergencies, illnesses, and diseases—like annual check-ups, immunizations and screening tests—are considered preventive. If you are enrolled in a medical plan, in-network preventive services are covered at 100%, with no payment needed from you.

Do I need a referral for my annual GYN exam?

No, this is considered preventive care. Female members may schedule an appointment for a routine annual exam with any OB/GYN in-network.

Enrolling or Life Event Status Change

Can I get health coverage outside Open Enrollment?

Outside Open Enrollment, you can only get health insurance 3 ways:

- With a life event status change, you qualify if you lose job-based coverage, have a baby, get married, or have certain other life changes, or based on estimated household income.
- Through Medicaid or the Children's Health Insurance Program (CHIP). Go to healthcare.gov for more information.
- HIPAA Special Enrollment due to loss of eligibility for other coverage and upon certain life events.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

What do I do for a life event status change?

You must notify the Benefits Helpline or HR Department within a limited number of days from the life event, in order to make a status change to your benefit selections.

If adding or removing dependents, you are required to submit specific documents, such as marriage license or birth certificate. The change will be inactive until proper documentation is received and approved.

See the full list of life event status changes listed on the Benefit Changes page in your benefit guide or defer to the plan documents.

What happens if I do not enroll within 30 days?

Benefits are subject to regulatory rules and if you do not enroll within the 30 days you will not be able to enroll again until next benefits open enrollment.

Explanation of Benefits (EOB)

What is an EOB?

EOB stands for Explanation of Benefits. This is a document sent to you to let you know a claim has been processed describing what costs it will cover for medical care or products received. The most important thing for you to remember is an EOB is NOT a bill.

To view the full FAQ list, click the link below or scan the QR code.

https://flipbooks.assuredpartners.com/30678/95470/index.html

Glossary of Terms

Watch a brief video reviewing key benefit-related terms.

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Home Health Care: Health care services a person receives at home.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. 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 provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued...

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

Cobra

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in Sherman College's medical plan, then PPACA may have little effect on you. Sherman College's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by Sherman College, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis.
(See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in Sherman College's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 1-800-318-2596.

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

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

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

CALIFORNIA – Medicaid
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+)
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

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

GEORGIA – 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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://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: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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: 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

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

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

MONTANA – Medicaid
Website: http://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: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Ph.: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
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: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

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

SOUTH DAKOTA - Medicaid
Website: http://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
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
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)

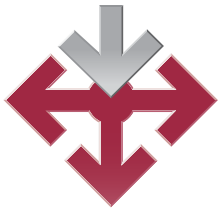
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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, 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



SHERMAN COLLEGE
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