WELCOME
TO OPEN ENROLLMENT

Plan Year: 2024

ILLINOIS WESLEYAN
UNIVERSITY

BENEFITS CHOICE & OPEN ENROLLMENT

Illinois Wesleyan University strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of your benefits and have provided the following Benefits Choice/Open Enrollment Guide for you to review. In addition to general benefit information, you will find links to benefit websites and plan summaries. Also linked are enrollment forms to be completed for new enrollments or changes to your current coverage for 2024.

Elections or changes you make during the open enrollment period will become **effective January 1, 2024.** If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to Marie in Human Resources at mgiusti@iwu.edu or (309) 556-3971.

As you review this guide, make sure to note the following:

- **Open Enrollment begins Monday, November 13**
- **Benefit Enrollment and Change forms due Friday, December 1, 2023.**
- **2024 Flexible Spending Account (FSA) and Health Savings Account (HSA) forms due Friday, December 1, 2023.** Current year elections will not carry forward for FSA and HSA. To continue participation, you must complete a new form for 2024.
- **Changes to Medical plan premiums** effective January 1, 2024.
- **Changes and Enhancements to the BCBS pharmacy coverage** for all plans effective January 1, 2024.
- **Changes to the Platinum and Gold medical plans** (deductibles, OOP) effective January 1, 2024.

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MEDICAL, DENTAL AND VISION COVERAGE

Who is eligible?

If you are a full-time employee at Illinois Wesleyan, you are eligible for the medical, dental and vision benefits outlined in this guide.

- Full-time staff employees are those who work at least 30 hours per week for a minimum of 9 months per year.
- Full-time faculty employees are those contracted to teach at least 4.5 course units for a minimum of 9 months per year.

In addition, an eligible employee's spouse, domestic partner and dependent children under 26 are eligible for medical, dental and vision coverage.

When to enroll?

The 2024 Open Enrollment period begins November 13 and runs through December 1. **All forms should be returned to HR by Friday, December 1.** The benefits you choose during open enrollment will become effective January 1, 2024.

How to enroll in the IWU health plan?

You will need to complete a new enrollment form for the following situations:

- If you are NOT currently enrolled and want to enroll in the BCBS medical plan, Principal dental plan or BCBS/EyeMed vision plan for 2024
- If you want to change your BCBS medical plan option
- If you want to terminate coverage in the BCBS medical plan, Principal dental plan or BCBS/EyeMed vision plan
- If you want to add or terminate dependent(s) to your coverage

If you do not want to make changes to your current insurance coverage and
If you do not want to contribute to a Flex or HSA plan during 2024,
Then you do not need to do anything.

Enrollment forms are available on page 13 of this guide, on the Human Resources webpage under Current Employees & Employee Benefits, or by contacting Marie in HR at mgiusti@iwu.edu or (309) 556-3971.

How to make changes after the Open Enrollment period?

Unless you experience a qualifying event during the calendar year, you cannot make changes to your benefits until the next Open Enrollment period. (See page 24 – Notice of Special Enrollment Rights for more details.)

Qualifying events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

If you experience a qualifying event during the year, contact Marie mgiusti@iwu.edu for assistance.

Medical Insurance

Blue Cross-Blue Shield of Illinois

The following changes to the IWU medical plans will take effect January 1, 2024:

- All medical plans will incur a premium increase: Platinum - 6%, Gold – 5.7%, Silver – 5.7%.
- Platinum Plan
    1) The individual deductible will increase from $500 to $750 (family from $1000 to $1500)
    2) The individual out-of-pocket maximum will increase from $2000 to $3000 (family from $4000 to $6000)
- Gold Plan
    1) Per IRS guidelines, the minimum individual deductible for high-deductible health plans (HDHP) will increase from $1500 to $1600 (family from $3000 to $3200)
    2) The individual out-of-pocket maximum will increase from $3000 to $3200 (family from $6000 to $6400)
- Silver Plan – There will be no changes to copays, deductibles or out-of-pocket amounts.
- The exclusion of gender reassignment surgery, including related services and supplies, will be removed.
- Pharmacy coverage will change from the Open Prescription Drug Formulary to the slightly more restrictive Balanced Drug Formulary.
- Prescription Enhancements to all three plans include the addition of the Split Fill and Flex Access programs. See page 6 for more information about these programs.

2024 Medical Premiums

There will be a 6% increase on the Platinum Plan and 5.7% increase on the Gold and Silver Plans for Plan Year 2024.

2024 Monthly Premiums	Employee Premium	IWU Contribution	Total
Platinum Plan			
Employee Only	$167	$734	$901
Employee + Child(ren)	$573	$1,049	$1,622
Employee + Spouse	$640	$1,162	$1,802
Family	$997	$1,796	$2,793
Gold Plan (HDHP) *			
Employee Only	$67	$763	$830
Employee + Child(ren)	$475	$1,019	$1,494
Employee + Spouse	$521	$1,138	$1,659
Family	$814	$1,758	$2,572
Silver Plan			
Employee Only	$71	$772	$843
Employee + Child(ren)	$430	$1,089	$1,519
Employee + Spouse	$475	$1,213	$1,688
Family	$733	$1,883	$2,616

* Again in 2024, Illinois Wesleyan will contribute $500 into an HSA for employees choosing Employee Only coverage on the Gold (HDHP) medical plan ($1,000 for Employee plus dependent(s) coverage).

2024 Plan Designs: In-Network Overview

	Platinum Plan	* Gold Plan (HDHP)	Silver Plan
Deductible:			
Individual	$750	$1,600	$1,700
Family	$1,500	$3,200	$3,400
Member Coinsurance:	20%	20%	20%
Out-of-Pocket Maximum:			
Individual	$3,000	$3,200	$3,400
Family	$6,000	$6,400	$6,800
Office Visit Copays:			
Primary Care	$25	Deductible & Coinsurance	$30
Specialist	$40	Deductible & Coinsurance	$50
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Urgent Care	$25	Deductible & Coinsurance	$30
Virtual Visits	$10	$48 (applied to deductible)	$15
Emergency Room	$100	Deductible & Coinsurance	$100
Hospital Services:			
In-Patient	$200	Deductible & Coinsurance	$200
Out-Patient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drug Copays:			
Generic	$10	Deductible & Coinsurance	$20
Formulary Brand	$30	Deductible & Coinsurance	$40
Non-Formulary Brand	$50	Deductible & Coinsurance	$60

Please note: IWU does not offer COBRA continuation benefits when employment ends.

* Notes specific to the Gold plan (HDHP):

(1) If you have dependents covered, the individual deductible and out-of-pocket amounts do not apply. Instead, the overall family deductible and out-of-pocket amounts must be met.

(2) Routine eye exams are not included on the IRS-approved preventative services list. They will not be covered at 100% on the Gold plan.

The BCBS Medical Plans include many additional benefits available to members, including:

- **Blue Access for Members** portal at www.bcbsil.com – Gives you the ability to check the status of your claims, view/save Explanation of Benefits forms (EOBs), check coverage details and Rx information, search for an in-network provider and request a new ID card.
- **BCBSIL phone app** – Gives you the same capabilities as Blue Access for Members, plus a Virtual ID card.
- **Virtual Visits** – With a virtual visit, you can meet and consult with a covered MD Live provider in the privacy of your own home. These providers can also write prescriptions and have them sent directly to your nearest pharmacy. Watch this YouTube video about Virtual Visits and sign up at www.MDLIVE.com.
- **Member Rewards** – Use Member Rewards to help find a lower-cost, quality provider for a recommended medical procedure and receive a reward.
    1) Select the provider
    2) Have the procedure or service done
    3) The claim is paid and so are you! You'll receive a reward check in the mail at home 6-8 weeks following the procedure.

  Search for providers offering Member Rewards online, through the BCBS phone app or by calling BCBS Member Services at (800) 548-1686.

Two new enhancements added to IWU BCBS Prescription Coverage for 2024 include:

- **Split/Fill.** This program applies to expensive medications that members are sometimes unable to tolerate (such as oral oncology drugs). It is not uncommon for a member to try several different medications before finding one that works well.
    1) Through this program, the member is given a partial amount of the medication at a prorated copay.
        - If they are able to tolerate the drug, they pick up the remainder of the prescription and pay the remainder of the copay.
        - If they do not tolerate it well, they try another alternative prescription.
    2) Less money is spent on medications that do not work; this is a savings to the member and the University.
- **FlexAccess.** This is a program that allows access to copay assistance programs (discounts or coupons on select prescription drugs offered by drug companies). This program saves money for the member and the University.
    - Over 80% of specialty drugs participate in the copay assistance program.
    - The member's copay is reduced at the time the prescription is filled.

DENTAL INSURANCE

The Principal

Dental coverage will remain the same for plan year 2024. There will be no change to the dental premiums for 2024 (see chart below).

IWU's optional dental insurance helps pay for your dental care. Studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Type of Service	Dental Plan Coverage
Preventive Services	Covered at 100% * Exams, cleanings (two times per calendar year) * X-rays (coverage may be limited depending on age of patient and type of service)
Annual Deductible	$50 for individual and $100 for family (applies to Basic and Major Services)
Basic Services	Covered at 80% after the deductible * Fillings, root canals, oral surgery (including wisdom teeth)
Major Services	Covered at 50% after the deductible * Caps, crowns, bridges
Annual Maximum	$1,000 maximum allowed per individual on an annual basis for Preventative, Basic and Major Services
Orthodontic Services	Covered at 50% with a lifetime maximum of $1,000 for dependent children under 19

2024 Monthly Premiums	Employee Premium	IWU Contribution	Total
Dental Plan			
Employee Only	$10	$31	$41
Employee + Child(ren)	$26	$71	$97
Employee + Spouse	$26	$71	$97
Family	$28	$73	$101

VISION INSURANCE

Blue Cross-Blue Shield/EyeMed

Illinois Wesleyan's optional vision insurance coverage and premiums remain the same in 2024. This coverage entitles you to specific eye care benefits including routine eye exams and other procedures. It also provides an allowance for the purchase of eyeglasses and contact lenses.

If you visit a provider listed in the BCBS-IL/EyeMed directory, your benefits include the following:

- Preventive Services:
  Routine Eye Exams – $10 copay (once every 12 months)
  - If you have the IWU BCBS Platinum or Silver medical plan, a routine annual eye exam is covered by your medical plan at 100%.
  - If you have the IWU BCBS Gold medical plan, a routine annual eye exam is not covered by your medical plan (due to IRS rules governing high-deductible health plans).
- Basic Services:
  Frames (once every 24 months) – up to $130 allowance
  Lenses or Contacts (once every 12 months) – See Summary of Vision Benefits for details on coverage.
- Additional Benefits:
  Discounts on additional pairs of glasses and non-prescription sunglasses.
  Discounts on Lasik vision correction.

2024 Monthly Premiums	Employee Premium
BCBS Vision Plan	
Employee Only	$7.52
Employee + Child(ren)	$15.06
Employee + Spouse	$14.30
Family	$22.14

DISABILITY INCOME BENEFITS

The Standard Insurance Company

Illinois Wesleyan provides full-time employees with short-term and long-term disability income benefits. Without disability coverage, you and your family might struggle to get by if you miss work due to an injury or illness.

We want to do everything we can to protect you and your family. That's why **IWU pays for the full cost** of short-term and long-term disability insurance—you are not responsible for paying any monthly premiums.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, you are not eligible to receive short-term disability benefits if you are receiving worker's compensation benefits.

	Short-term Disability	Long-term Disability
Benefits Begin	On the date you become a member	On the date you become a member
Benefits Waiting Period	30 days	180 days
Percentage of Income Replaced	70% of the first $2,857 of your Pre-disability Earnings, reduced by Deductible Income	60% of the first $20,000 of your Pre-disability Earnings, reduced by Deductible Income
Maximum Benefit	$2,000 before reduction by Deductible Income	$12,000 before reduction by Deductible Income

The Standard disability policy also provides an EAP program with up to three confidential counseling sessions per issue for employees and their dependents.

BASIC LIFE INSURANCE

The Standard Insurance Company

Illinois Wesleyan provides eligible employees with group life and accidental death and dismemberment (AD&D) insurance. The life insurance benefit is 1.5 times your salary.

IWU pays for the full cost of the life insurance benefit—you are not responsible for paying any monthly premiums.

The Standard life insurance policy also provides access to Travel Assist. This is a program offering medical assistance when you are traveling 100 miles from home or internationally for business or pleasure.

Contact Marie at mgiusti@iwu.edu if you would like to update your life insurance beneficiaries.

FLEXIBLE SPENDING ACCOUNTS

BPC – Benefit Planning Consultants

A Flexible Spending Account (FSA) allows you to pay for predictable, eligible health care expenses or expenses related to the care of a dependent child or adult with pre-tax dollars, lowering your taxable income and saving you money.

You're going to spend money on copays, prescriptions and/or day care anyway…
Why not get reimbursed with your pre-tax contributions??

HEALTH CARE FSA:

- The 2024 Flex maximum has not yet been officially released by the IRS. The proposed 2024 Health Care FSA maximum amount is $3,200. For employees paid monthly, this equals $266.67 per month. For employees paid biweekly (26 pays), this equals $123.08 per pay.
- You will receive an FSA VISA debit card loaded with your full 2024 annual election. You can use the FSA VISA debit card to pay for copays, prescriptions and other qualified health care expenses.

DEPENDENT CARE FSA:

Dependent Care FSAs allow you to contribute pre-tax dollars to pay for qualified dependent care expenses. The maximum amount you can contribute each year is $5,000 (or $2,500 if married and filing separately).

HOW DO I ENROLL?

- Enrollment in an FSA account is an annual event. New elections must be made even if you participated last year. **You must re-enroll to contribute to your Flex account each year.**
- Return the Flex Enrollment form to Human Resources (209 Holmes Hall) as soon as possible, but **no later than Friday, December 1, 2023.**
- If you do not want to participate in an FSA during 2024, you do not need to complete an enrollment form.
- Contact Marie at mgiusti@iwu.edu to learn how a Flex plan can save you money.

Things to remember about an FSA:

- Based on IRS guidelines, money set aside in an FSA is subject to a **use it or lose it** provision. However, the IWU FSA Plan allows a **grace period** so that expenses incurred on or before March 15 of one year may be submitted for reimbursement from account dollars set aside in the previous year.
- If you have a balance in your 2023 FSA and **choose the Gold plan option for 2024**, you must incur all reimbursable expenses by December 31, 2023.
- You and/or your spouse cannot contribute to a Health Care FSA while also contributing to an HSA.
- You cannot make a change to your FSA election during the year unless you incur a **qualifying event**.
- Most pharmacies send prescription files to the BPC VISA debit card system. **However, BPC VISA debit card users must submit documentation for other medical, dental and vision services to BPC to verify expense eligibility.** BPC may reach out to you to obtain any missing documentation. Failure to submit proper documentation may cause the debit card to be deactivated until expenses can be adjudicated.
- **FSA VISA debit cards from BPC are good for three years**. If your card is set to expire, you will receive a new card around the first of the year.

HEALTH SAVINGS ACCOUNTS

HSA Bank

Health Savings Accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany the **IWU Gold medical plan option** (a high-deductible health plan - HDHP). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

- **An HSA is a tax-saver. –** HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is portable. –** The money in your HSA is carried over from year to year and is yours to keep, even if you leave IWU.
- You and/or your spouse cannot contribute to an HSA while also contributing to a Health Care FSA.
- **IWU Contribution –** During 2024, IWU will contribute $500 into the HSA account for employees choosing Employee Only coverage with the Gold BCBS plan ($1000 for Employee plus dependent(s) coverage).
- **2024 Annual Contribution Limit –** The maximum contribution to an HSA during 2024 is $4,150 for employee-only coverage ($8,300 for employee plus dependent(s) coverage).
  - The annual limit includes the contribution made by IWU.
  - If you are 55 or older, you can make an additional "catch-up" contribution of $1,000.
  - You can change your contribution amount at any time throughout the year as long as you don't exceed your annual maximum.
  - To participate in an HSA, you cannot be receiving Social Security benefits.
  - **You must re-enroll to contribute to your HSA each year.**

Return the HSA Contribution form to Human Resources (209 Holmes Hall) as soon as possible, but **no later than Friday, December 1, 2023.**

HSA CARRYOVER EXAMPLE

Mary is a healthy 25-year-old single woman who contributes $1,000 each year to her HSA. Her plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Mary's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings.)

Year 1	
HSA Balance	$1,000
Total Expenses: - Prescription drugs: $150 - Preventive care services: $0 (covered by insurance)	($150)
HSA Rollover to Year 2	$850
Since Mary did not spend all of her HSA dollars, she did not need to pay any additional amounts out-of-pocket this year.	

→

Year 2	
HSA Balance	$1,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	($300)
HSA Rollover to Year 3	$1,550
Once again, since Mary did not spend all of her HSA dollars, she did not need to pay any additional amounts out-of-pocket this year.	

ADDITIONAL BENEFITS

Employee Assistance Program (EAP)

The EAP benefit provides counseling and consultation services. Services are available to help employees resolve personal difficulties that may be affecting their quality of life or job performance. Eligible employees and their immediate family members receive unlimited telephonic counseling and four face-to-face counseling sessions per issue per academic year. For confidential assistance, please call (800) 252-4555 or (800) 225-2527.

TIAA - Retirement Accounts

The TIAA website offers links to presentations and calculators to assist in developing the best retirement plan for Illinois Wesleyan employees.

- If you want to begin making contributions to your retirement account or change the amount you contribute, return the Salary Reduction Agreement form to Marie at mgiusti@iwu.edu or 209 Holmes Hall.
- Click here to schedule a VIRTUAL meeting with a Millennium investment advisor. Speak individually with an advisor about your retirement questions, investment options and get guidance to achieve your retirement goals.
- Visit www.tiaa.org/webinars to register for an upcoming retirement webinar or watch a previous webinar on-demand.

Tuition Scholarships

See Tuition Scholarship Programs on the HR Webpage for details regarding eligibility, benefits and the enrollment process for Illinois Wesleyan Admissions, CIC Tuition Exchange and Tuition Exchange programs. If you have specific questions regarding tuition benefits, contact Kat in the HR Office at kjiardin@iwu.edu.

Voluntary Accidental Death & Dismemberment Insurance

This optional coverage through Zurich allows employees to secure accidental death and dismemberment insurance through the IWU group plan. An employee may enroll as an individual, or as a family with spouse and/or eligible dependents. Payment is by monthly payroll deduction. Complete the enrollment form and return to Marie in the HR Office if you would like to enroll.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about any of the benefits described in this guide, please contact HR.

QUESTIONS & ANSWERS

Are there any changes effective January 1, 2024?

- There are changes to medical premiums for 2024 (see p 4 for details).
- There are changes to plan coverage on the Platinum and Gold plans for 2024 (see p 4-5 for details).

What forms must be completed?

- BCBS-IL medical plan enrollment/change form
  – Complete if you have previously opted out and want to enroll yourself and/or your dependents.
  – Complete if you want to terminate coverage for yourself and/or your dependents.
  – Complete if you want to change medical plan options.
- Principal dental plan enrollment/change form
  – Complete if you have previously opted out and want to enroll yourself and/or your dependents.
  – Complete if you want to terminate coverage for yourself and/or your dependents.
- BCBS/EyeMed vision enrollment form
  – Complete if you have previously opted out and want to enroll yourself and/or your dependents.
  – Complete if you want to terminate coverage for yourself and/or your dependents.
- BPC Flexible Spending Account enrollment form
  – Complete if you want to enroll in a health care or dependent care FSA during 2024.
  Your 2023 Flex election will not be carried forward into 2024.
- HSA Bank contribution form
  – Complete if you want to contribute to your HSA during 2024.
  Your 2023 HSA election will not be carried forward into 2024.

Where do I find the enrollment forms?

- Enrollment/change forms – links to the forms are included in the previous question above
- Enrollment/change forms are on the Human Resources webpage under Current Employees and Employee Benefits
- Contact Marie at mgiusti@iwu.edu

When are the forms due and where do I return them?

- Forms are due by **December 1, 2023** and must be returned to Human Resources (209 Holmes Hall).

If you do not want to make changes to your current insurance coverage or
If you do not want to contribute to a Flex or HSA plan during 2024,
You do not need to do anything.

What if I have other questions?

- Link to Open Enrollment - Frequently Asked Questions
- Contact Marie in Human Resources at mgiusti@iwu.edu or 309.556.3971.

Illinois Wesleyan University
Benefits Notices

1312 Park St
Bloomington, IL 61701
www.iwu.edu

Employer's Children's Health Insurance Program (CHIP) Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility —

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

General FMLA Notice

EMPLOYEE RIGHTS - THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave; * and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE (1-866-487-9243)

TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information 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, we are asking that you not provide any genetic information when responding to this 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.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

How Can I Get More Information?

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

Marie Giusti
1312 Park St – Holmes Hall 209
Bloomington, IL 61701
(309) 556-3971, mgiusti@iwu.edu

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

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer name Illinois Wesleyan University	2. Employer Identification Number (EIN) 37-0662594	
3. Employer address 1312 Park St	4. Employer phone number (309) 556-3971	
5. City Bloomington	6. State Illinois	7. ZIP code 61701
8. Who can we contact about employee health coverage at this job? Marie Giusti		
9. Phone number (309) 556-3971	10. Email address mgiusti@iwu.edu	

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

- As your employer, we offer a health plan to:
  ☑ Some employees. Eligible full-time staff employees are those who work at least 30 or more hours per week for a minimum of 9 months per year. Eligible full-time faculty employees are those who teach at least 4.5 course units for a minimum of 9 months per year.
- With respect to dependents:
  ☑ We do offer coverage. Eligible dependents include an employee's spouse, domestic partner and dependent children under age 26.
- ☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2024 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator at (309) 556-3971.

Newborns' and Mothers' Health Protection Act Notice

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

Notice of Special Enrollment Rights

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

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

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Marie Giusti at 1312 Park St, Bloomington, IL 61701, (309) 556-3971, mgiusti@iwu.edu.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- 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 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 (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.*

Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.