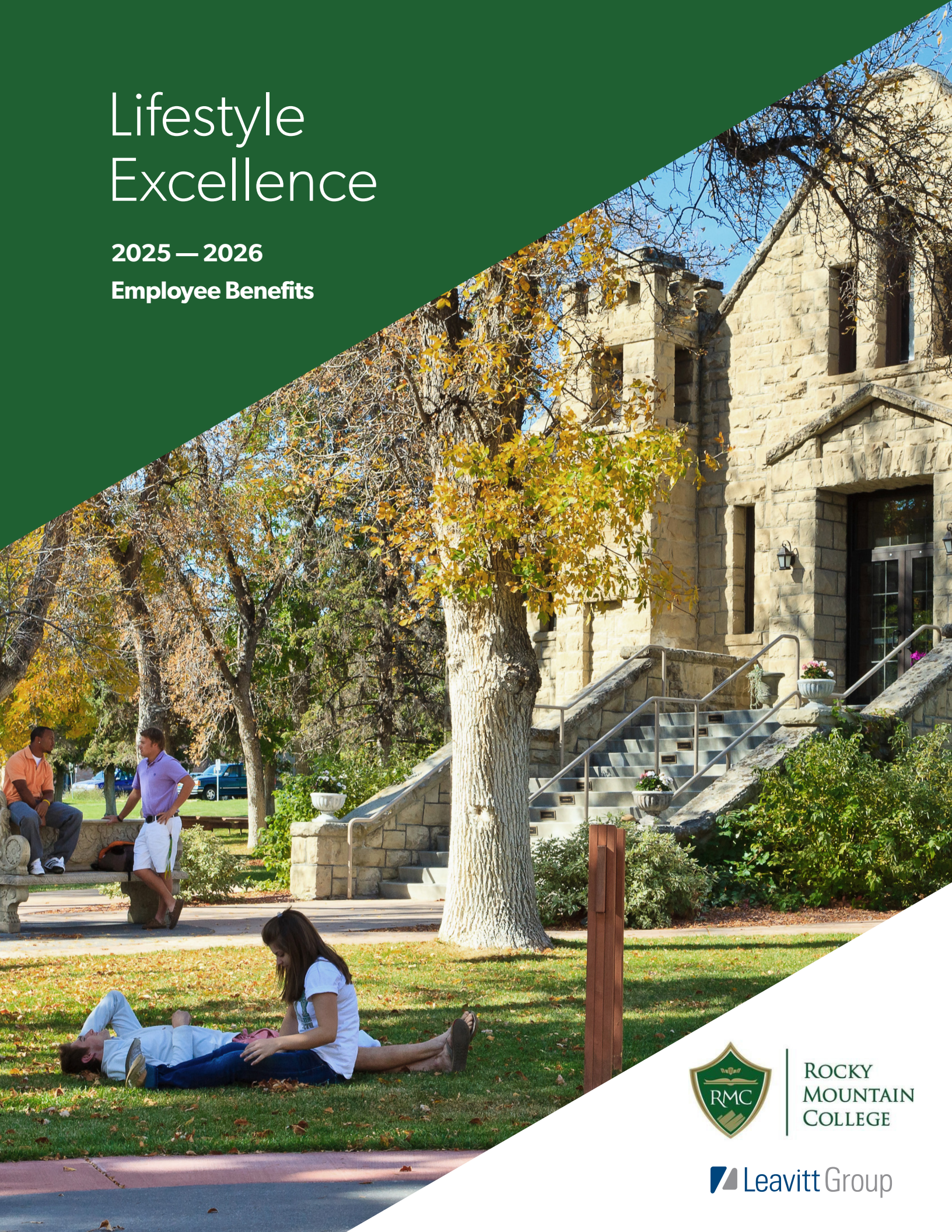
Lifestyle Excellence

2025 — 2026

Employee Benefits



Rocky Mountain College

Leavitt Group

Introduction

We are pleased to provide you with this summary of benefits. Our employees are our most important resource, and Rocky Mountain College spends a substantial amount of money every year to provide benefits to protect our employees and their families.

This summary outlines eligibility, enrollment options, and coverage effective dates. It is not a legal plan document and does not imply a guarantee of coverage. Full details of each benefit plan are contained within the summary plan description (SPD). In the event of a discrepancy, the SPD prevails. A copy of each benefit SPD may be obtained by contacting human resources.

Rocky Mountain College reserves the right to add to, modify, or delete any policy and/or benefit program at any time, with or without notice. Furthermore, no information contained in this document in any way constitutes a contract for employment, express or implied, for any specified period of time. Rocky Mountain College is an Equal Opportunity and Affirmative Action Employer, including veterans and disabled individuals.

Medical Eligibility

Benefits will be offered to full-time employees on the first of the month following your date of hire, unless otherwise noted, or during annual open enrollment.

When Coverage Begins

Rocky Mountain College's health plan year is January 1 through December 31. Rocky Mountain College's open enrollment window is in April/May, and elections become effective on July 1.

Employees may elect benefits for themselves, their spouse, and eligible dependent children, including:

- Spouse or domestic partner
- Children up to age 26; or, if fully dependent on you for support due to ongoing mental or physical disability, regardless of age

You must be a member of the health plan to provide medical benefits for your family members. You may also make changes mid-year if you experience a qualified change in family status.

Your Benefits Plan

Rocky Mountain College is pleased to offer a comprehensive benefits package to our valued employees.

In the following pages, you will learn more about the benefits Rocky Mountain College offers. You will also see how choosing the right combination of benefits can help protect you and your family's health and financial future.

CARRIER	PLAN	WEBSITE	PHONE #
Boon-Chapman	Medical, FSA, Dependent FSA	**www.boonchapman.com**	800.252.9653
Boon Champions	Member Concierge Service	EMAIL **boonchampions@boonchapman.com**	888.660.0467
SmithRx	Pharmacy	**www.mysmithrx.com**	844.454.5201
NEW **Delta Dental**	Voluntary Dental	**www.deltadental.com**	800.932.0783
VSP	Voluntary Vision	**www.vsp.com**	800.877.7195
Mutual of Omaha	Employer-Paid Life, LTD, Voluntary Life, STD, Accident & Critical Illness	**www.mutualofomaha.com**	877.999.2330
Mutual of Omaha	Employee Assistance Program	**www.mutualofomaha.com/eap**	800.316.2796
FEDlogic	Personal Navigator for State and Federal Benefits	**www.fedlogicgroup.com**	877.837.4196
Cancer Expert Now	Professional Consultation Advice	**www.cancerexpertnow.com/access/welcome**	855.946.5735
HealthEquity	Health Savings Account (HSA)	**www.healthequity.com**	866.346.5800
TIAA	Defined Contribution 403(b) Plan	EMAIL **deidre.mcmunn@tiaa.org**	720.572.6145
Empower Retirement	Financial Advisor	EMAIL **aderse@stifel.com**	406.252.2447
Leavitt Group	Account Executive	**Cindy Zipperian** EMAIL **cindy-zipperian@leavitt.com**	406.439.1016

WHEN CAN I ENROLL?

You can sign up for benefits at any of the following times:

- After completing your eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

When can I make changes?

Generally, you can only change your benefit choices during the annual benefits enrollment period. You may be able to change some of your benefit choices when you have a change in status—provided you properly notify your employer and the change is permitted under the plan terms. If you have a family status change, contact the HR department within 30 days to complete the necessary steps. For more information, refer to your benefits booklet.

EXAMPLES OF THESE CHANGE-IN-STATUS EVENTS MAY INCLUDE:

Marriage Status Changes

- Your marriage
- Your divorce or legal separation
- Death of your spouse

Child Status Changes

- Birth or adoption of an eligible child
- Death of your covered child
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

Employment Status Changes

- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your spouse's work status that affects their benefits

Medical Plan and Rx Summary

ADMINISTERED BY BOON-CHAPMAN

The below plans utilize the Aetna Provider Network. You can find a list of providers at www.aetna.com/asa or call 800.252.9653.

BENEFITS	HDHP IN-NETWORK	TRADITIONAL IN-NETWORK
Pre-Tax Savings	HSA	FLEX
Deductible (calendar year)	$3,300 individual $5,700 family	$1,500 individual $3,000 family
Coinsurance	0%	20%
Out-of-Pocket Maximum	$3,300 individual $5,700 family	$3,000 individual $6,000 family
Office Visit	Deductible applies	$30 co-pay
Preventive Care	Covered 100%, deductible waived	
Prescription Drug Coverage	**Preventive**	
Generic	$7 co-pay	$10 co-pay
Formulary	$30 co-pay	$25 co-pay
Non-Formulary	30%	$50 co-pay
Mail Order (90-day supply)	$14 generic $60 formulary 30% non-formulary	2x co-pay
Non-Preventive Prescriptions	Medical deductible applies	N/A

Medical Premiums

	HDHP (EMPLOYEE-PAID PER MONTH)*	TRADITIONAL (EMPLOYEE-PAID PER MONTH)*
Employee Only	$111.34	$207.09
Employee + Spouse	$515.13	$762.39
Employee + Child(ren)	$413.79	$603.53
Employee + Family	$677.21	$1,002.25

**Those that are eligible for the wellness credit will continue to receive it.*

TERMS TO KNOW

Deductible

The insurance deductible is the amount of money you will pay for an insurance claim(s) before the coverage kicks in and the company starts paying your claims.

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

IMPORTANT REMINDER

When you show your Boon Chapman ID card to providers, make sure that they know that Boon Chapman is the medical plan and they need to contact Boon Chapman to verify eligibility.

Aetna is the provider network and eligibility cannot be verifed through Aetna.

New for July 1, 2025 -
Boon Champions Program

With your Member Concierge, you gain a dedicated expert who goes the extra mile to answer questions, resolve plan issues, and ensure a seamless health plan experience. Exceptional support isn't just a perk, it's a priority.

WHAT WE DO

- Simplify understanding plan benefits and claims processing.
- Guide you through the Boon-Chapman website and member portal.
- Locate in-network providers and confirm availability.
- Assist with gathering and preparing documentation like medical records, itemized bills, insurance verification, and subrogation details.
- Take full responsibility for resolving employees issues, no extra "homework" required from them.
- Proactively notify participants and providers of potential claim denials.
- Support with predeterminations, medical, pre-athorizations, appeals, and prescription drug approvals.
- Assist with Healthcare Bluebook utilization.
- Provide expert assistance with our mobile app.
- Ensure timely updates with consistent follow-ups.

WHY CHOOSE US?

The goal of Boon Champions Service is to elevate participants' overall Health Plan experience. Our focus is on being highly supportive and thorough, providing clear, detailed information while bridging any gaps and proactively resolving issues that may arise.

CONTACT US

 boonchampions@boonchapman.com  888.660.0467  www.boonchapman.com

Emergency Room or Urgent/Walk-in Care?

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars.

If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition? The following outlines how you can determine whether you should visit urgent / walk-in care or the emergency room.

EMERGENCY ROOM

The emergency room (ER) is equipped to handle conditions that are life-threatening and that may require advanced treatment. Patients are seen according to the seriousness of their condition in relation to the other patients.

You should go to the nearest ER if you experience any of the following:

- Signs of a heart attack or stroke
- Seizures or loss of consciousness
- Fainting, dizziness, weakness
- Problems breathing, shortness of breath
- Serious eye, head, neck, or back injuries
- Babies needing immediate care
- Broken bones, compound fractures
- Uncontrolled bleeding
- Deep knife or gunshot wounds
- Moderate to severe burns
- Allergic reactions
- High fever
- Severe abdominal pain
- Severe vomiting and/or diarrhea
- Suicidal or homicidal feelings
- Suspected drug overdose or poisoning

URGENT / WALK-IN CARE

Urgent / walk-in care clinics are equipped to handle non-life-threatening illnesses and injuries.

Some examples of conditions that could be treated in an urgent / walk-in care clinic include:

- Controlled bleeding or cuts that require stitches
- Diagnostic services (x-rays, lab tests)
- Infections, such as ear infections or pink eye
- Cold or flu symptoms
- Minor broken bones (e.g., toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes
- Animal or insect bites
- Lower back pain
- Urinary tract infections
- Minor allergic reactions
- Minor injuries or pain

Voluntary Vision Enhanced Benefit Summary

INSURED BY VISION SERVICE PLAN (VSP)

BENEFITS	IN-NETWORK	FREQUENCY
Exam	$10 co-pay	12 months
Materials	$25 co-pay	
Lenses • *Single* • *Bifocal* • *Trifocal*	$25 co-pay	12 months
Frames	$200 allowance	24 months
Contacts	Medically necessary, covered in full; elective, up to $130	12 months

Voluntary Vision Premiums

	VISION (EMPLOYEE-PAID PER MONTH)
Employee Only	$12.48
Employee + Spouse	$19.97
Employee + Child(ren)	$20.39
Employee + Family	$32.87

Save money with VSP offers on glasses, sunglasses, contacts, LASIK, diabetes care, and hearing aids. Go to **www.vsp.com** and click on the 'Offers' tab.

New - Voluntary Dental Benefit Summary

DELTA DENTAL

BENEFIT DESCRIPTION	IN-NETWORK
Deductible (calendar year)	$50 individual $150 family
Maximum Annual Benefit (Increase for 2025)	**$1,500**
Preventive	Covered at 100%, deductible waived
Basic	80%
Major	50%

Voluntary Dental Premiums

	DENTAL (EMPLOYEE-PAID PER MONTH)
Employee Only	$40.59
Employee + Spouse	$81.09
Employee + Child(ren)	$80.05
Employee + Family	$110.97

TERMS TO KNOW

Preventive & Diagnostic Care

Examples are exams, cleanings, and x-rays.

Basic

Examples are fillings, oral surgery, and root canals.

Major

Examples are crowns, dentures, and bridges.

Benefit Year Maximum

The most the dental plan will pay towards each covered members' dental services each calendar year.

Employer-Paid Life and AD&D Benefit Summary

INSURED BY MUTUAL OF OMAHA

BENEFITS	COVERAGE
Life Benefit	$50,000
AD&D Benefit	$50,000
Age Reduction	Age 65: 65% of original amount Age 70: 50% of original amount

Employer-Paid LTD Benefit Summary

INSURED BY MUTUAL OF OMAHA

BENEFITS	COVERAGE
Elimination Period	90 days
Weekly Benefit	60% of monthly earnings, up to $5,000 per month
Benefit Duration	To age 65; reducing benefit duration

Voluntary STD Benefit Summary

INSURED BY MUTUAL OF OMAHA

BENEFITS	COVERAGE
Elimination Period	14 days
Weekly Benefit	60% of weekly earnings, up to $1,000 per week
Maximum Benefit Duration	11 weeks
Monthly Rate Per $10 of Weekly Benefit	$0.43

Voluntary Life and AD&D Benefit Summary

INSURED BY MUTUAL OF OMAHA

BENEFITS	EMPLOYEE	SPOUSE	DEPENDENT
Life Benefit	5x annual salary, up to $500,000	100% of employee life amount, up to $250,000	$2,000, up to $10,000
AD&D Benefit	Same as life	Same as life	Same as life
Guaranteed Issue	$150,000	$30,000	$10,000
Age Reduction	65% at age 70; 45% at age 75; 30% at age 80; 20% at age 85; and 15% at age 90+		Up to age 26, if FT student

Employee Assistance Program

INSURED BY MUTUAL OF OMAHA

Assistance for you and your eligible dependents, including;

- In-person help for short-term issues; up to 3 sessions with a counselor per person, per year
- Toll-free phone and web access 24/7
- Unlimited phone access to legal, financial, and work-life services
- Financial consultations and referrals
- Work-life services for assistance with dependent and elder care, substance abuse, addiction, healthy lifestyles, and much more

Go to mutualofomaha.com/eap or call (800) 316-2796

Will Preparation Services

PROVIDED BY MUTUAL OF OMAHA THROUGH EPOQ, INC.

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.

Create your will at willprepservices.com and use code MUTUALWILLS to register

Hearing Discount Program

ADMINISTERED BY MUTUAL OF OMAHA THROUGH AMPLIFON HEARING HEALTH CARE

Program Benefits

In addition to your hearing care benefit, you will have access to complimentary aftercare, including:

- Custom hearing solutions — wide choice of products from the industry's leading brands
- Risk-free trial — find your right fit by trying your hearing aids for 60 days
- Follow-up care — ensures a smooth transition to your new hearing aids
- Battery support — battery supply or charging station to keep your hearing aids powered
- Warranty — 3-year coverage for loss, repairs, or damage
- Financing — no interest for those who qualify
- Savings for family and friends — your parents, siblings, in-laws, and friends qualify, too

Accessing Your Benefits is as Easy as...

1. Call Amplifon at 1-888-534-1747 and a patient care advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information, and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

To learn more, visit amplifonusa.com/mutualofomaha

Voluntary Worksite Benefit

INSURED BY MUTUAL OF OMAHA

Group Accident Insurance

Benefits that pay for covered accidents while you are on the road to recovery. Mutual of Omaha's coverage provides a lump-sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Express Benefit – $75

If an insured person is injured as the result of an accident, an express benefit of $75 will be paid upon notification of the accident. This benefit is payable once per covered accident for each insured person.

Examples of covered injuries include:

- Broken bones
- Eye injuries
- Burns
- Ruptured discs
- Torn ligaments
- Concussion
- Lacerations
- Coma due to a covered injury

Examples of how accident coverage can help with your expenses:

40-year-old claimant | Accident: Fall at home
Injury: Anterior cruciate ligament (ACL) tear (knee ligament injury)

Out-of-Pocket Expenses Incurred:

- $1,500 deductible
- $875 coinsurance for surgery ($3,500 x 25%)
- $120 co-pay for six physical therapy visits

Total out-of-pocket expenses: $2,495

Benefits Paid:

- $150 emergency room visit
- $100 appliance (knee brace)
- $300 outpatient surgery facility service
- $800 surgical ligament tear repair
- $150 physical therapy sessions (6)

Total benefit paid under policy: $1,500

Group Accident Rates

EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
$14.56	$22.33	$25.94	$35.23

Voluntary Worksite Benefit

INSURED BY MUTUAL OF OMAHA

Group Critical Illness Insurance

Benefits that assist a person when they have a serious or critical illness such as a heart attack, organ transplant, cancer, stroke, and much more. Critical illness insurance can be used to cover your deductible, coinsurance, travel to treatment locations, unpaid time from work, and other out-of-pocket costs.

Benefits also include childhood development illness for children such as cerebral palsy, structural congenital defects, genetic disorders, and type 1 diabetes.

Employees and their spouses can elect coverage of $5,000 up to a maximum benefit of $15,000, and dependent children can have coverage up to 25% of the employee's elected critical illness amount up to a maximum of $4,000.

The critical illness program offers a health screening benefit that pays a flat annual benefit of $100 for a health screening and a hearing discount benefit program that includes discounts on hearing aids and batteries.

Critical Illness Premium Rates

AGE BAND	EMPLOYEE*† MONTHLY RATES PER $1,000		SPOUSE* MONTHLY RATES PER $1,000	
	Non-Tobacco	Tobacco**	Non-Tobacco	Tobacco**
<30	$0.34	$0.38	$0.38	$0.43
30 - 39	$0.63	$0.76	$0.64	$0.82
40 - 49	$1.34	$1.88	$1.38	$2.14
50 - 59	$2.50	$4.30	$2.84	$5.12
60 - 69	$4.79	$9.60	$5.47	$11.17
70 - 79	$9.17	$17.06	$10.23	$19.45
80 - 99	$13.37	$22.24	$14.76	$25.21

**Employee and spouse premiums are calculated with the employee's age as of the effective date of the plan. Rates are adjusted once each year on the plan anniversary date that coincides with or follows the day an employee reaches the starting age of the next age band.*

†Child insurance is automatic. A separate premium is not required.

***Tobacco rates apply for any use of tobacco or nicotine replacement within the past 12 months.*

Pre-Tax Savings Options

Rocky Mountain College offers ways to help you and your family save money by offering various pre-tax savings options to help pay for future qualified expenses. What are the differences between a Medical Flex, Dependent Care Flex, and a Health Savings Account?

	MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	HEALTH SAVINGS ACCOUNT (HSA)
What is it?	Use pre-tax dollars to pay for qualified medical, RX, dental, and vision expenses for you and your dependents	Use pre-tax dollars to pay for eligible expenses related to care for your child, disabled spouse, elderly parent, or other dependent so you (and your spouse) can work	Use pre-tax dollars to pay for qualified medical, RX, dental, and vision expenses for you and your dependents
Who is eligible?	Employees who are not enrolled in an HSA	Dependent care flex is available to all employees whether on the plan or not	Employees enrolled in the RMC HDHP Not enrolled in Medicare A or B Cannot be claimed as a dependent on someone else's tax return Not covered by another health plan that is not an HDHP
Who owns the account?	Your employer, but it's your money	Your employer, but it's your money	Individual/employee
What are the annual contribution limits?	$3,300	$5,000 ($2,500 if filing separately)	$4,300 individual $8,550 family
Who funds the account?	Employees can contribute pre-tax dollars through payroll deductions		
Can unused funds be rolled over from year to year?	You can rollover a maximum of $660 into the next plan year	No; subject to "use it or lose it" rule	Yes
Can I take my account balance with me if I leave the company?	No	No	Yes
Can I pay for non-qualified expenses?	No	N/A	Yes, but the amount is taxed as income and incurs a 20% penalty (no penalty if distributed after death, disability, or age 65)
Do I get a debit card to use for expenses?	Yes	Yes	Yes
How do I manage my accounts?	Submit claims, upload receipts, and set up reimbursement at: **flextogo.wealthcareportal.com**		Manage account through: **www.HealthEquity.com**

Healthcare in Retirement is Expensive – Investing in Your H.S.A.

SOURCE: HEALTHEQUITY

Healthcare costs are rising with no end in sight. According to recent estimates, the average couple will need $300,000+ to cover out-of-pocket medical expenses in retirement.

That's how much they will need if they retire today. With inflation, these figures could be even higher in the future.

Consider that Medicare, isn't free, it has premiums just like your health insurance today. Prescriptions tend to cost more in retirement also. The irony is that healthy couples will need to absorb even more costs, as longer life expectancy translates into more healthcare spending.

Bottom line: You can't pan for retirement without also planning for your healthcare. That's why more members than ever are investing in their Health Savings Account (HSA) to build long-term retirement and healthcare savings.

OPTIMIZE YOUR RETIREMENT SAVINGS STRATEGY

Given that a significant portion of retirement spending will go toward healthcare costs, it may not be ideal to use a 401(k) as your sole retirement savings vehicle. An HSA offers much more flexibility and empowers you to pay for qualified medical expenses in retirement—in many instances, tax free. Therefore, it could be prudent to use a 401(k) in conjunction with an HSA. For many people, an effective contribution strategy may follow these steps.

MAX OUT YOUR EMPLOYER'S HSA MATCH

Many organizations may offer an annual seed contribution. Other organizations offer an ongoing HSA contribution match. Usually the match is dollar-for-dollar up to a specified limit. Given the short- and long-term flexibility associated with your HSA, it's important to capture this match first. Don't leave free HSA money on the table!

Keep in mind that your employer's HSA contributions count toward your overall contribution limits. You can always view the latest IRS contribution limits at IRS.gov.

MAX OUT YOUR HSA

Do your best to contribute up to the IRS contribution limits. Members 55+ can contribute an additional $1000 beyond these limits. In most cases, it may be advantageous to maximize contributions to your HSA before maxing out your 401(k). FICA savings alone could justify prioritizing the HSA.

More on this can be found at: www.healthequity.com/library/why-you-should-consider-investing-your-hsa

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

Workplace Advantage

ADMINISTERED BY LEAVITT GREAT WEST INSURANCE

All employees have personal insurance needs for home, auto, renters, and recreational vehicles. Leavitt Great West offers the opportunity for a complete review of your personal insurance coverage and can provide you with a quote any time throughout the year. Contact Beth Cecrle at Leavitt Great West to get started.

Beth Cecrle: 406.577.0165 or email beth-cecrle@leavitt.com

Leavitt Great West Insurance Services: 406.252.4104
2345 King Ave., Ste. E | Billings, MT 59102

Additional Benefits

SMITHRX CONNECT PROGRAM

Help control your medication costs through the SmithRx Connect Program. The SmithRx Connect Program identifies alternate sources for your high-cost specialty and branded medications to be covered at little or no cost to you.

The SmithRx team will help you navigate the process with their team of experts. If you are taking medications that qualify for the program, you will receive communication from the SmithRx team. Please engage with the SmithRx team and provide them the information requested and this will help prevent any delays in accessing your medications at a lower cost.

If you would like more information on this program, call **844-454-5201** or email **help@smithrx.com**.

PURE INFUSION SUITES

Save costs and have a better infusion therapy experience with Pure Infusion Suites. Pure Infusion offers spacious infusion suites with high-quality care. Medications are administered by an experienced RN and you can enjoy a relaxed and welcoming environment with free Wi-Fi, snacks, and drinks.

Pure Infusion provides only high-quality, brand-name pharmaceuticals and follows the same safety protocols as your local hospital or doctor's office. Pure Infusion Suites is located in Billings and Great Falls, MT.

You can access more information at **www.pureinfusionsuites.com** or call **406-702-1327**.

Additional Benefits

CONNECTDME

ConnectDME is the durable medical supplier for Rocky Mountain College employees enrolled in the health plan. ConnectDME offers over 4,000 products with free shipping and handling, next-day delivery, and in-home setup and training:

- CPAP, BIPAP, and supplies
- Nebulizers
- Wheelchairs
- Crutches and braces
- Diabetic supplies

For more information, go to www.connectdme.com or call 918-851-6249.

FEDLOGIC

Rocky Mountain College has partnered with FEDlogic to provide state and federal benefit information and advocacy to employees and their family members.

Reasons to call FEDlogic:

- You have reached or are approaching Medicare age and need to learn more
- You are currently on dialysis (ESRD)
- You are approaching retirement age and want to learn more about your Social Security benefits
- You need assistance navigating Medicaid, Marketplace, or COBRA
- You have a child with a disability or born premature
- You need help exploring alternative healthcare avenues based on your income

For more information on this program, call 877-837-4196 to schedule an appointment and let FEDlogic answer your questions. This service is confidential, unlimited, and free to you as an employee with Rocky Mountain College.

Additional Benefits

CANCER EXPERT NOW

If you or your family member have been diagnosed with cancer, we are here for you. Contact us to connect with one of the world's top cancer doctors—all from the comfort of your home.

Cancer Expert Now virtually connects you with a world-class physician who can offer guidance about your diagnosis. You will speak with a live expert over an audio or video call.

Cancer Expert Now is a service offered by your employer free of charge. You, your spouse, children, parents, and parents-in-law can use our service at any time, however many times you need.

There is no question too big or small. Ask about…

- A screening
- A new or existing diagnosis
- A procedure or surgery
- A treatment plan
- Medications
- Survivor protocols
- A condition requiring a specialist
- And more…

Cancer Expert Now is here for you!

Contact us to schedule an appointment with a top expert.

carenavigator@onviv.com **+1 855-946-5735** **CancerExpertNow.com/access/welcome**

We're available Monday–Friday, 8:00 AM–5:30 PM ET.

Global Emergency Services

ADMINISTERED BY ASSIST AMERICA

One simple phone call to the number on your Assist America identification card will connect you to:

- A state-of-the-art operations center
- Worldwide response capabilities
- Experienced crisis management professionals
- Air and ground ambulance service providers

Assist America completely arranges and pays for the assistance services it provides without limits on the cost. This alleviates many of the obstacles and potential expenses that can be caused by medical emergencies away from home.

Assist America is not insurance; rather, it is a provider of global emergency services.* Assist America's services do not replace medical insurance during emergencies away from home. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage.

Key Services:

- Medical consultation, evaluation, and referral
- Hospital admission assistance
- Emergency medical evacuation
- Medical monitoring
- Medical repatriation
- Prescription assistance
- Compassionate visit
- Care of minor children
- Return of mortal remains
- Emergency trauma counseling
- Lost luggage assistance
- Interpreter and legal referrals
- Pre-trip information
- Return of vehicle
- And much more!

**All services must be arranged and provided by Assist America. No claims for reimbursement will be accepted. The Assist America services in this brochure are only intended to serve as a general overview of the emergency travel assistance services available. The services available to you through your plan may vary from what is listed in this brochure. For a complete description of the services that are provided to you by your plan, please contact your service certificate provided by your plan administrator and/or the fulfillment material provided by Assist America.*

REFERENCE

01-AA-EBM-01155

If you require medical assistance and are more than 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:

1.800.872.1414
Inside USA

+1.609.986.1234
Outside USA

Or email: medservices@assistamerica.com

Stay connected to Assist America by downloading our app from the Apple Store or Google Play.

Contact Information

Questions regarding any of this information can be directed to:

Marcy Buster
Rocky Mountain College
marcella.buster@rocky.edu
406.657.1043

Cindy Zipperian
Leavitt Great West Insurance
cindy-zipperian@leavitt.com
406.443.1060

Tracy Czudak
Rocky Mountain College
tracy.czudak@rocky.edu
406.657.1160

Erin Weenum
Leavitt Great West Insurance
erin-weenum@leavitt.com
406.281.7970

Confidentiality Disclosure

Notice of Privacy Practices

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Your Rights

You have the right to:

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

Your Choices

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

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

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

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Important Legal Notices Affecting Your Health Plan Coverage

Initial and Annual Enrollment Notices – Guide

The Women's Health Cancer Rights Act Of 1998 (WHCRA)

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

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

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

Newborns Act Disclosure – Federal

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

Notice of Special Enrollment Rights

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

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

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

- Coverage is lost under Medicaid or a state CHIP program
- You or your dependents become eligible for a premium assistance subsidy from the state

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

Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at the telephone number listed at the end of this document and we will work with you to develop another way to qualify for the reward.

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's 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, dial 1-877-KIDS NOW, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your state for more information on eligibility.

ALABAMA – MEDICAID	ALASKA – MEDICAID
Website: **http://myalhipp.com/** Phone: 1.855.692.5447	The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1.866.251.4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**
ARKANSAS – MEDICAID	**CALIFORNIA – MEDICAID**
Website: **http://myarhipp.com/** Phone: 1.855.MyARHIPP (855.692.7447)	Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp** Phone: 916.445.8322 Fax: 916.440.5676 Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

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

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)

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

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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**

Phone: 1.800.657.3739

MISSOURI – MEDICAID

Website: **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. 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**

Medicaid Phone: 609.631.2392

CHIP Website: **http://www.njfamilycare.org/index.html**

CHIP Phone: 1.800.701.0710

NEW YORK – MEDICAID

Website: **https://www.health.ny.gov/health_care/medicaid/**

Phone: 1.800.541.2831

NORTH CAROLINA – MEDICAID	NORTH DAKOTA – MEDICAID
Website: **https://medicaid.ncdhhs.gov/** Phone: 919.855.4100	Website: **https://www.hhs.nd.gov/healthcare** Phone: 1.844.854.4825
OKLAHOMA – MEDICAID AND CHIP	**OREGON – MEDICAID AND CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1.888.365.3742	Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1.800.699.9075
PENNSYLVANIA – MEDICAID AND CHIP	**RHODE ISLAND – MEDICAID AND CHIP**
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** Phone: 1.800.692.7462 CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)** CHIP Phone: 1.800.986.KIDS (5437)	Website: **http://www.eohhs.ri.gov/** Phone: 1.855-697.4347, or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – MEDICAID	**SOUTH DAKOTA – MEDICAID**
Website: **https://www.scdhhs.gov** Phone: 1.888.549.0820	Website: **http://dss.sd.gov** Phone: 1.888.828.0059
TEXAS – MEDICAID	**UTAH – MEDICAID**
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
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)
WINCONSIN – MEDICAID AND CHIP	**WYOMING – MEDICAID**
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1.800.362.3002	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1.800.251.1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare and 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 Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment
- Death of the employee
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator. Any notice you provide must state the name of the Plan or Plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying even and the date it occurred. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Marcy Buster, RMC Chief HR Officer
406.657.1043
marcella.buster@rocky.edu