

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact ASR Health Benefits at (800) 968-2449.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining authorization for certain services, following a pre-approved treatment plan, or following certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact ASR Health Benefits at (800) 968-2449.

Women's Health and Cancer Rights Act of 1998 (Also Known As Janet's Law)

Did you know that your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services? These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema). Call your Claim Administrator at (616) 957-1751 or 1-800-968-2449 for more information.

Notice to Plan Participants – Notice of Privacy Practices Available

The U.S. Department of Health and Human Services has issued regulations as part of the Health Insurance Portability and Accountability Act of 1996. These regulations, known as the Standards for Privacy of Individually Identifiable Health Information, were effective on April 14, 2003 (or April 14, 2004 for small health plans) and control how your medical information may be used and disclosed and how you can access this information. Please be advised that your health benefits plans maintain a current Notice of Privacy Practices to inform you of the policies that they have established to comply with the Standards for Privacy. This Notice describes the responsibilities of the plans and any third party assisting in the administration of claims regarding the use and disclosure of your protected health information, and your rights concerning the same.

This Notice is available to you upon request by contacting your company's Privacy Official or Human Resources Director.

<p>Notice of Creditable Coverage for Premier Plan and Standard Plan Enrollees Important Notice about Your Prescription Drug Coverage and Medicare</p>

This Notice affects individuals who are enrolled in or eligible to enroll in Medicare. You or a family member may be enrolled in Medicare owing to age (on or after attaining age 65), a disability, or permanent kidney failure (end-stage renal disease). If no one in your family is enrolled in or eligible to enroll in Medicare, the information in this Notice does NOT apply to you.

This Notice provides information about your current prescription drug coverage under the Health Benefit Plan offered by Andrews University (Employer) and the prescription drug coverage for people with Medicare. You may receive this Notice or an updated version of this Notice on an annual basis. You may also request an additional copy of this Notice at any time.

For further information about this Notice or your coverage under the Health Benefit Plan, you may contact Employer at the following address or telephone number:

Andrews University
Dan Agnetta
Old Highway 31
Berrien Springs, Michigan 49104-0840
(269) 471-3871

If this Notice applies to you or a family member, you should read it carefully and keep it where you can find it.

<p>Information You Need to Know about Medicare Prescription Drug Coverage</p>

- 4 Medicare prescription drug coverage became available in 2006 to everyone who is eligible for Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage.
- 4 You can join a Medicare prescription drug plan or Medicare Advantage plan when you first become eligible for Medicare and each year from October 15 through December 7. In addition, if you lose coverage through Employer through no fault of your own, you will be eligible to sign up for a Medicare prescription drug plan at that time, through a special two-month enrollment period.
- 4 All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. Medicare beneficiaries will need to carefully review the materials provided by each prescription drug plan available to them to determine whether it provides the coverage they need.

<p>Information You Need to Know about Employer's Prescription Drug Coverage</p>

- 4 Employer currently offers eligible employees and their eligible dependents prescription drug coverage under the Health Benefit Plan. Participants in the Health Benefit Plan who are enrolled in, or eligible for, Medicare can continue their coverage under the Health Benefit Plan.

- 4 Employer has determined that the prescription drug coverage offered under the Health Benefit Plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay. **In other words, for most people, the prescription drug coverage under the Health Benefit Plan is at least as good as the coverage you can get from a Medicare prescription drug plan, which means this coverage is “creditable coverage.”** As a result, participants in the Health Benefit Plan who are also enrolled in or eligible to enroll in Medicare can keep their current coverage under the Health Benefit Plan and not pay a higher premium if they later decide to enroll in a Medicare prescription drug plan.

Frequently Asked Questions

If I decide to enroll in a Medicare prescription drug plan, can I also keep my coverage under the Health Benefit Plan?

Yes. Enrollment in a Medicare prescription drug plan will generally not affect your eligibility for coverage under the Health Benefit Plan. However, as long as you are actively working for Employer, coverage under the Health Benefit Plan will usually be your primary coverage. Therefore, you may not need to enroll in a Medicare prescription drug plan while you are actively working for Employer.

If I decide to drop my coverage under the Health Benefit Plan and enroll in a Medicare prescription drug plan and Medicare Parts A and B, can I re-enroll in the Health Benefit Plan if I later decide I do not like the Medicare plan?

Yes. However, if you drop coverage under the Health Benefit Plan, you will generally not be able to re-enroll until the next open enrollment period.

Before dropping coverage under the Health Benefit Plan, you should consider that your coverage under the Health Benefit Plan pays for other health expenses in addition to prescription drugs, which may or may not be covered under Medicare Parts A and B and the Medicare prescription drug coverage to the same extent that they are covered under the Health Benefit Plan.

You should compare your current coverage under the Health Benefit Plan with the coverage and cost of the Medicare prescription drug coverage plans providing coverage in your area (and Medicare Parts A and B) before deciding whether to drop coverage under the Health Benefit Plan.

What happens if I elect to keep my coverage under the Health Benefit Plan and not enroll in Medicare prescription drug coverage until I leave Employer?

Because the prescription drug coverage under the Health Benefit Plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, it is considered “creditable coverage.” As a result, you can choose to join a Medicare prescription drug plan later without paying a higher premium (a penalty).

Each year, Medicare beneficiaries will have the opportunity to enroll in a Medicare prescription drug plan between October 15 and December 7. You will also be entitled to a special two-month enrollment period if your coverage under the Health Benefit Plan ends through no fault of your own. However, individuals who drop or lose coverage under the Health Benefit Plan but do not enroll in Medicare prescription drug coverage within a certain period of time may pay more to enroll in Medicare prescription drug coverage later.

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (i.e., creditable coverage), your monthly premium may increase by at least 1 percent of the Medicare base premium per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19 percent higher than the Medicare base premium. You may pay this higher premium (a penalty) as long as you have Medicare coverage. In addition, you may have to wait until the next October to enroll.

Where can I get more information about my options under Medicare prescription drug coverage?

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook. Medicare beneficiaries will get a copy of the handbook in the mail every year from Medicare; representatives from Medicare prescription drug plans may also contact beneficiaries directly. More information about Medicare prescription drug plans is also available as follows:

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

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

Remember: Keep this Notice. If you decide to enroll in a Medicare prescription drug plan, you may be required to provide a copy of this Notice when you join to show whether you have maintained creditable coverage and whether you are required to pay a higher premium (a penalty).

<p>Notice of Non-Creditable Coverage for High Deductible Health Plan Enrollees Important Notice about Your Prescription Drug Coverage and Medicare</p>

This Notice affects individuals who are enrolled in or eligible to enroll in Medicare. You or a family member may be enrolled in Medicare owing to age (on or after attaining age 65), a disability, or permanent kidney failure (end-stage renal disease). If no one in your family is enrolled in or eligible to enroll in Medicare, the information in this Notice does NOT apply to you.

This Notice provides information about your current prescription drug coverage under the Health Benefit Plan offered by Andrews University (Employer) and the prescription drug coverage for people with Medicare. You may receive this Notice or an updated version of this Notice on an annual basis. You may also request an additional copy of this Notice at any time.

If this Notice applies to you or a family member, you should read it carefully. The information in this Notice can help you decide whether you want to join a Medicare prescription drug plan.

For further information about this Notice or your coverage under the Health Benefit Plan, you may contact Employer at the following address or telephone number:

Andrews University
Dan Agnetta
Old Highway 31
Berrien Springs, Michigan 49104-0840
(269) 471-3871

<p>Information You Need to Know about the Medicare Prescription Drug Coverage and Your Current Coverage Under the Health Benefits Plan</p>

- 4 Prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage.
- 4 All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- 4 Employer currently offers eligible employees and their eligible dependents prescription drug coverage under the Health Benefit Plan. Enrollment in, or eligibility for, Medicare will generally not affect eligibility for coverage under the Health Benefit Plan.
- 4 Employer has determined that the prescription drug coverage offered under the Health Benefit Plan is, on average for all plan participants, NOT expected to pay as much as the standard Medicare prescription drug coverage will pay and is considered “**non-creditable**” coverage. **This fact is important because most likely you will get more help with your prescription drug costs if you join a Medicare prescription drug plan than if you have prescription drug coverage only under the Health Benefit Plan. This fact is also important because you may pay a higher premium (a penalty) if you do not join a Medicare prescription drug plan when you first become eligible.**
- 4 You can keep your coverage under the Health Benefit Plan, but because your coverage under the Plan is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. When you make your decision, you should compare your current

coverage under the Health Benefit Plan, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Frequently Asked Questions

When can I enroll in a Medicare prescription drug plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 through December 7. Additionally, if you lose or decide to drop your coverage under the Health Benefit Plan, you will be eligible for a two-month special enrollment period in which you can sign up for a Medicare prescription drug plan. However, you may have to pay a higher premium (a penalty) because you did not have creditable coverage under the Health Benefit Plan.

If I decide to enroll in a Medicare prescription drug plan, can I also keep my coverage under the Health Benefit Plan?

Yes. You can enroll in a Medicare prescription drug plan and keep your coverage under the Health Benefit Plan. Enrollment in a Medicare prescription drug plan will generally not affect your eligibility to receive coverage under the Health Benefit Plan.

If you are covered under both the Health Benefit Plan and a Medicare prescription drug plan, the Health Benefit Plan will generally be your primary coverage as long as you are actively working for Employer. This fact is true even though the Health Benefit Plan provides “non-creditable” prescription drug coverage and you will pay more for Medicare prescription drug coverage if you wait to enroll in a Medicare prescription drug plan until after you leave Employer.

You should compare your current coverage under the Health Benefit Plan with the coverage and cost of the Medicare prescription drug plans providing coverage in your area (and Medicare Parts A and B). In doing so, remember that your coverage under the Health Benefit Plan pays for other health expenses in addition to prescription drugs, which may or may not be covered under Medicare Parts A and B to the same extent that they are covered under the Health Benefit Plan.

You may decide that you want coverage under both the Health Benefit Plan and a Medicare prescription drug plan. Alternatively, you may decide that you do not need coverage under both the Health Benefit Plan and a Medicare prescription drug plan and may elect to be covered only under Medicare.

If I decide to drop my coverage under the Health Benefit Plan and enroll in Medicare Parts A and B and a Medicare prescription drug plan, but later I decide I would also like to have coverage under the Health Benefit Plan, can I re-enroll in the Health Benefit Plan?

Yes. However, if you drop coverage under the Health Benefit Plan, you will generally not be able to re-enroll in it until the next open enrollment period.

What happens if I elect not to enroll in a Medicare prescription drug plan now because I have coverage under the Health Benefit Plan, but I want to enroll in Medicare prescription drug coverage at some time in the future?

The prescription drug coverage under the Health Benefit Plan is NOT creditable, so if you delay enrollment in a Medicare prescription drug plan, you may have to pay a higher premium (a penalty) for as long as you have Medicare prescription drug coverage.

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

Where can I get more information about my options under Medicare prescription drug coverage?

More detailed information about Medicare plans that offer prescription drug coverage will be available in the “Medicare & You” handbook. Medicare beneficiaries will get a copy of the handbook in the mail every year from Medicare; representatives from Medicare prescription drug plans may also contact beneficiaries directly. More information about Medicare prescription drug plans is also available as follows:

1. [Visit www.medicare.gov](http://www.medicare.gov).
2. Call your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for the telephone number).
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, visit the Social Security Administration online at <http://www.socialsecurity.gov>, or call them at 1-800-772-1213 (TTY 1-800-325-0778).



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact ASR Health Benefits at (800) 968-2449.

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

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name Andrews University	4. Employer Identification Number (EIN) 38-1627600	
5. Employer address Old Highway 31	6. Employer phone number (269) 471-3302	
7. City Berrien Springs	8. State Michigan	9. ZIP code 49104-0840
10. Who can we contact about employee health coverage at this job? Beverly Brown, Silvia Arteaga, and Lilian Akawobsa		
11. Phone number (if different from above) (269) 471-6326, (269) 471-3886, or (269) 471-6721	12. E-mail address beverlyb@andrews.edu , arteaga@andrews.edu , or offridam@andrews.edu	

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

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

Individuals designated by the employer as “Hourly Employees” working in full-time or part-time employment for at least 30 hours or more per week. Individuals employed by the employer and working at a 50% or more appointment percentage are also considered to be eligible employees. All eligible employees must complete any required waiting period for plan coverage (if applicable) and must submit any required application for health plan coverage on a form that is acceptable to the employer.
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are:
 1. The employee’s legal spouse. However, spouses working in full-time employment with other available employer-based coverage are generally not eligible to enroll for coverage under the plan.
 2. The employee’s natural child, stepchild, legally adopted child, or a child placed with the employee for adoption (age limits apply).
 3. A child who has been placed under the legal guardianship of the employee and is considered a “dependent” of the employee for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986, as amended (age limits apply).
 4. A child for whom the employee is obligated to provide medical care coverage under an order or judgment of a court of competent jurisdiction and could be considered a “dependent” of the employee for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986, as amended (age limits apply).
 5. A child for whom the employee is obligated to provide medical coverage under a Qualified Medical Child Support Order (age limits apply).
 - ☐ We do not offer coverage.
- ☒ If checked, this coverage meets the minimum-value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum-value standard²?

☐ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum-value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum-value standard². (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

Notice of Privacy Practices

Please review this notice carefully, as it describes how one or more of the health plans of Andrews University (collectively the “Plan”) and any third party assisting in the administration of claims may use and disclose your health information, and how you can access this information. This notice is being provided to you pursuant to the federal law known as HIPAA and an amendment to that law known as HITECH and is effective September 23, 2013. If you have any questions about this notice, please contact Dan Agnetta, the Privacy Officer at Andrews University, at Old Highway 31, Berrien Springs, Michigan 49104-0840, or at agnetta@andrews.edu. The Plan has been amended to comply with the requirements described in this notice.

The Plan’s Pledge Regarding Health Information. The Plan is committed to protecting your personal health information. The Plan is required by law to protect medical information about you. This notice applies to medical records and information the Plan maintains concerning the Plan. Your personal doctor or health care provider may have different policies or notices regarding the use and disclosure of your health information created in his or her facility. This notice will describe how the Plan may use and disclose health information (known as “protected health information” under federal law) about you, as well as the Plan’s obligations and your rights regarding this use and disclosure.

Use and Disclosure of Health Information. The following categories describe different ways that the Plan uses and discloses protected health information. The Plan will explain and present examples for each category but will not list every possible use or disclosure. However, all of the permissible uses and disclosures fall within one of these categories:

- § *For Treatment.* The Plan may use or disclose your health information to facilitate treatment or services by providers. For example, the Plan may disclose your health information to providers, including doctors, nurses, or other hospital personnel who are involved in your care.
- § *For Payment.* The Plan may use and disclose your health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, or to determine benefit responsibility under the Plan. For example, the Plan may disclose your health history to your health care provider to determine whether a particular treatment is a qualifying health expense or to determine whether the Plan will reimburse the treatment. The Plan may also share your health information with a utilization review or precertification service provider, with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.
- § *For Health Care Operations.* The Plan may use and disclose your health information in order to operate the Plan. For example, the Plan may use health information in connection with the following: (1) quality assessment and improvement; (2) underwriting, premium rating, and Plan coverage; (3) stop-loss (or excess-loss) claim submission; (4) medical review, legal services, audit services, and fraud and abuse detection programs; (5) business planning and development, such as cost management; and (6) business management and general Plan administration.
- § *To Business Associates and Subcontractors.* The Plan may contract with individuals and entities known as business associates to perform various functions or provide certain services. In order to perform these functions or provide these services, business associates may receive, create, maintain, use, or disclose your health information, but only after they sign an agreement with the Plan requiring them to implement appropriate safeguards regarding your health information. For example, the Plan may disclose your health information to a business associate to administer claims or to provide support services, but only after the business associate enters into a Business Associate Agreement with the Plan. Similarly, a business associate may hire a subcontractor to assist in performing functions or providing services in connection with the Plan. If a subcontractor is hired, the business associate may not disclose your health information to the subcontractor until after the subcontractor enters into a Subcontractor Agreement with the business associate.
- § *As Required by Law.* The Plan will disclose your health information when required to do so by federal, state, or local law. For example, the Plan may disclose health information when required by a court order in a litigation proceeding, such as a malpractice action.

- § *To Avert a Serious Threat to Health or Safety.* The Plan may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. The Plan would disclose this information only to someone able to help prevent the threat. For example, the Plan may disclose your health information in a proceeding regarding the licensure of a physician.
- § *To Health Plan Sponsor.* The Plan may disclose health information to another health plan maintained by the Plan sponsor for purposes of facilitating claims payments under that plan. In addition, the Plan may disclose your health information to the Plan sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and the Plan sponsor's HIPAA privacy policies and procedures.

Special Situations. The Plan may also use and disclose your protected health information in the following special situations:

- § *Organ and Tissue Donation.* The Plan may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- § *Military and Veterans.* If you are a member of the armed forces, the Plan may release your health information as required by military command authorities. The Plan may also release health information about foreign military personnel to the appropriate foreign military authority.
- § *Workers' Compensation.* The Plan may release health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illnesses.
- § *Public Health Risks.* The Plan may disclose health information for public health activities, such as prevention or control of disease, injury, or disability; report of births and deaths; and notification of disease exposure or risk of disease contraction or proliferation.
- § *Health Oversight Activities.* The Plan may disclose health information to a health oversight agency for activities authorized by law, e.g., audits, investigations, inspections, and licensure, which are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- § *Law Enforcement.* The Plan may release health information if requested by a law enforcement official in the following circumstances: (1) in response to a court order, subpoena, warrant, or summons; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) to report a crime; and (4) to disclose information about the victim of a crime if (under certain limited circumstances) the Plan is unable to obtain the person's agreement.
- § *Coroners and Medical Examiners.* The Plan may release health information to a coroner or medical examiner if necessary (e.g., to identify a deceased person or determine the cause of death).

Rights Regarding Health Information. You have the following rights regarding your protected health information that the Plan maintains:

- § *Right to Access.* You may request access to health information containing your enrollment, payment, and other records used to make decisions about your Plan benefits, including the right to inspect the information and the right to a copy of the information. You may request that the information be sent to a third party. You must submit a request for access in writing to the Privacy Officer. The Plan may charge a fee for the costs of copying, mailing, or other supplies associated with your request. The Plan may deny your request in certain very limited circumstances, and you may request that such denial be reviewed. If the Plan maintains your health information electronically in a designated record set, the Plan will provide you with access to the information in the electronic form and format you request if readily producible or, if not, in a readable electronic form and format as agreed to by the Plan and you.
- § *Right to Amend.* If you feel that the Plan's records of your health information are incorrect or incomplete, you may request an amendment to the information for as long as the information is kept by or for the Plan. You must submit a request for amendment in writing to the Privacy Officer. Your written request must include a supporting reason; otherwise the Plan may deny your request for an amendment. In addition, the Plan may deny your request to amend information that is not part of the health information kept by or for the Plan, was not created by the Plan (unless the person or entity that

created the information is no longer available to make the amendment), is not part of the information that you would be permitted to inspect and copy, or is accurate and complete.

- § *Right to an Accounting of Disclosures.* You may request an accounting of your health information disclosures except disclosures for treatment, payment, health care operations; disclosures to you about your own health information; disclosures pursuant to an individual authorization; or other disclosures as set forth in the Plan sponsor's HIPAA privacy policies and procedures. You must submit a request for accounting in writing to the Privacy Officer. Your request must state a time period for the accounting not longer than six years and indicate your preferred form (e.g., paper or electronic). The Plan will provide for free the first accounting you request within a 12-month period, but the Plan may charge you for the costs of providing additional lists (the Plan will notify you prior to provision and you may cancel your request). Effective at the time prescribed by federal regulations, you may also request an accounting of uses and disclosures of your health information maintained as an electronic health record if the Plan maintains such records.
- § *Right to Request Restrictions.* You may request a restriction or limitation on your health information that the Plan uses or discloses for treatment, payment, or health care operations or that the Plan discloses to someone involved in your care or the payment for your care (e.g., a family member or friend). For example, you could ask that the Plan not use or disclose information about a surgery you had. You must submit a request for restriction in writing to the Privacy Officer. Your request must describe what information you want to limit; whether you want to limit the Plan's use, disclosure, or both; and to whom you want the limits to apply (e.g., your spouse). The Plan is not required to agree to your request.
- § *Right to Request Confidential Communications.* You may request that the Plan communicate with you about health matters in a certain way or at a certain location (e.g., only by mail or at work), and the Plan will accommodate all reasonable requests. You must submit a request for confidential communications in writing to the Privacy Officer. Your written request must specify how or where you wish to be contacted. You do not need to state the reason for your request.
- § *Right to a Paper Copy of this Notice.* If you received this notice electronically, you may receive a paper copy at any time by contacting the Privacy Officer.

Genetic Information. If the Plan uses or discloses protected health information for Plan underwriting purposes, the Plan will not (except in the case of any long-term care benefits) use or disclose health information that is your genetic information for such purposes.

Breach Notification Requirements. In the event unsecured protected health information about you is "breached," the Plan will notify you of the situation unless the Plan determines the probability is low that the health information has been compromised. The Plan will also inform HHS of the breach and take any other steps required by law.

Changes to this Notice. The Plan reserves the right to revise or change this notice, which may be effective for your protected health information the Plan already possesses as well as any information the Plan receives in the future. The Plan will notify you if this notice changes.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan by contacting the Privacy Officer in writing. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information. The Plan will use and disclose protected health information not covered by this notice or applicable laws only with your written permission. If you permit the Plan to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization. However, the Plan is unable to retract any disclosures it has already made with your permission.

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 are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ (Click on Programs, then Medicaid, and then Health Insurance Premium Payment [HIPP]) Phone: 1-800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oi/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 (Click on Health Care and then Medical Assistance) Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820 (HMS Third-Party Liability)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT – Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
<http://www.dol.gov/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

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

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

Appeal

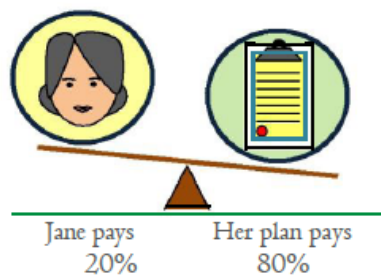
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

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

Co-insurance

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



(See page 4 for a detailed example.)

Complications of Pregnancy

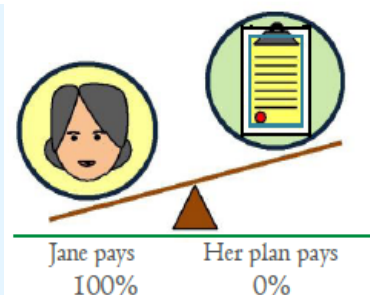
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

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

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

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

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

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

Network

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

Non-Preferred Provider

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

Out-of-network Co-insurance

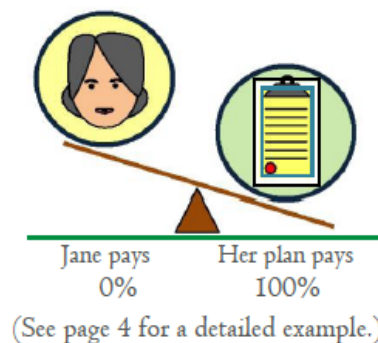
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do *not* contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do *not* contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

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



Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

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

Preferred Provider

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

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

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

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

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

How You and Your Insurer Share Costs - Example

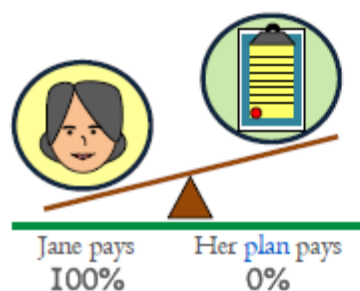
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage
Period

December 31st
End of Coverage Period



Jane hasn't reached her \$1,500 deductible yet

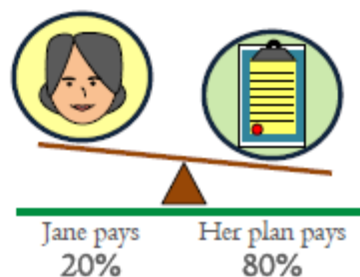
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more
costs



Jane reaches her \$1,500 deductible, co-insurance begins

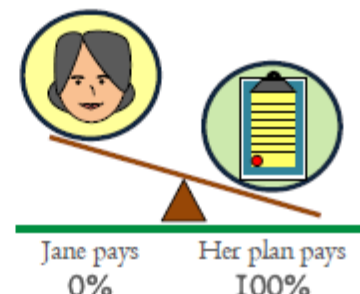
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more
costs



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200

Appendix A: U.S. Department of Labor Distribution Guidelines for Plan Materials

The U.S. Department of Labor (DOL) requires that plan materials be distributed within a specific timeframe, and it has established different rules for printed and electronic distribution. Below is a brief summary of the DOL guidelines for distribution of plan materials. These rules apply to the distribution of the Plan Document / Summary Plan Description, any Summary of Material Modification documents that amend that item, the Summary of Benefits and Coverage (SBC) documents, and the various notices included in this Compliance Document. Distribution of plan materials in multiple formats is also acceptable; for example, employees with work-related computer access may receive an electronic copy and employees without work-related computer access may receive a printed copy. It is your organization's responsibility to ensure compliance with these requirements.

PRINTED DISTRIBUTION

Printed copies of plan materials may be distributed through multiple methods, but every effort to ensure the receipt of the item(s) must be taken. ASR recommends mailing items first class via U.S. Postal Service (USPS). If the employee covers any dependents, the envelope must be addressed to *[Employee Name] and Family* so that it is evident that the contents are not intended only for the employee. It is important to be certain that the materials are sent to the employee's current address, and a separate copy of such materials be sent to any enrolled dependent who resides at a different address. For your organization's protection, a record should be maintained that can serve as evidence that the materials were supplied appropriately, including the address(es) to which it was sent, how the envelope was addressed, and the date it was mailed. ASR recommends the use of "[Certificate of Mailing](#)"-level handling for this purpose. Certificate of Mailing (not to be confused with Certified Mail) captures the data above and is relatively inexpensive.

Alternatively, your organization may use hand delivery for employees who do not cover any dependents. As above, it is important to maintain records that can serve as evidence that plan materials were supplied appropriately. If hand delivery is used, ASR recommends obtaining the employee's signature to acknowledge receipt.

ELECTRONIC DISTRIBUTION

Employees with Work-Related Computer Access

Employees with work-related computer access can be provided a copy of plan materials electronically via e-mail if the following requirements are met:

1. The e-mail system lets the sender know if the message is undeliverable.
2. The system protects an individual's account and benefit confidentiality (i.e., the individual needs a password to log on to his/her workstation).
3. The sender includes a statement in the e-mail explaining the document's significance.
4. The sender provides, upon request, a paper copy free of charge.

Plan materials may also be made available through a Website instead of via e-mail. Below are the requirements for posting plan materials online.

1. Appropriate and necessary means are used in order to ensure materials posted on the company's Website results in actual receipt (see below for further details).
2. Plan materials are prepared and furnished in accordance with all applicable requirements (e.g., timing and format requirements).
3. Written or electronic notice is provided to employees directing them to the Website at the time the plan materials are posted. This notice must also describe the significance of the materials and communicate the recipient's right receive a paper copy of the item upon request.
4. A paper copy of the plan materials is provided upon request without charge.

In order to ensure that your organization has taken appropriate and necessary measures to make ensure the posting of plan materials results in actual receipt, ASR recommends that the following steps be taken:

1. Add a prominent link from the Website's homepage to the separate section that contains the electronic plan materials.
2. Provide directions on the Website for how to replace a lost or forgotten password to the extent one is needed
3. Maintain plan materials on the Website for a reasonable period of time following notice to employees of their availability.

If plan materials are distributed via e-mail or posted on the company Website, it is important to adhere to HIPAA Privacy guidelines. Suggestions to remain compliant when electronically distributing materials include suppressing the recipient e-mail addresses from being displayed to all individuals who receive the e-mail using the blind carbon copy (Bcc) function, e-mailing the document to all employees, even if they do not participate in the plan, or e-mailing the document to each participating individual one at a time.

Please note that the DOL has specifically advised that setting up a stand-alone kiosk or computer station for employees to review the document is unacceptable. The DOL has also advised that distributing materials using a flash drive or compact disk (CD) is unacceptable as well because it is not reasonable to assume that individuals will be able to access and read the CD or flash drive merely because they are formatted in a commonly accessible fashion. If your organization wishes to distribute plan materials using a flash drive or CD, ASR recommends that your organization obtain affirmative consent from the individual before distributing plan materials in such a fashion in accordance with the requirements outline below for electronic distribution to an employee without work-related computer access.

The federal government has developed optional, alternative distribution instructions that apply only to the SBC document when it is given to individuals eligible for, but not enrolled for, plan coverage. If your organization would like to consider performing a separate electronic distribution of the SBC document to such individuals, please visit <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and review Q10 for more details.

Electronic Distribution for Employees without Work-Related Computer Access

Your organization may provide plan materials electronically to employees who do not have work-related computer access; however, further notices and consents for electronic delivery to those individual are required. In addition to the provisions listed in the section above, the following requirements apply:

1. Affirmative consent for electronic distribution must be obtained from the individual. Before consent can be obtained, a pre-consent statement must be furnished that explains the following:
 - A. The types of documents that will be provided electronically
 - B. The individual's right to withdraw consent at any time without charge
 - C. The procedures for withdrawing consent and updating information (e.g., updating the address for receiving electronic disclosure)
 - D. The right to request a paper version and its cost (if any)
 - E. The hardware and software requirements needed to access the electronic document

The regulations permit the pre-consent statement to be provided electronically if the employer has a current and reliable e-mail address for the recipient.

2. If the hardware or software requirements change, a revised statement must be provided and a renewed consent from each individual must be obtained.
3. If the documents are to be provided via the Internet, the affirmative consent must be given in a manner that reasonably demonstrates the individual's ability to access the information in electronic form, and the individual must have provided an address for the receipt of electronically distributed documents.
4. The employer must keep track of individual electronic delivery addresses, individual consents, and the actual receipt of e-mailed documents by recipients.

It may be necessary to provide a hard copy of plan materials to such individuals in order to ensure compliance if, for example, the recipient neglects to return the signed consent form or does not provide a current e-mail address. Please refer to the "Printed Distribution" section above for the applicable guidelines.