

Self-Funded Benefit Plan Notice

To comply with the notice requirement specified in Michigan Compiled Laws 550.932, the following Plan-related information is being provided to participants in the Andrews University Employee Benefit Plan (the “Plan”). Currently, the following self-funded benefits are offered under the Plan: medical and prescription drug, dental, and vision. For additional Plan information, including the benefit and eligibility provisions that govern the Plan, refer to the Plan Document or Summary Plan Description.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. Insurance may be purchased to protect the Employer against large claims. However, if for some reason the medical and prescription drug, dental, and vision expenses that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses. The Claim Administrator, ASR Health Benefits, processes claims and does not insure that any medical and prescription drug, dental, and vision expenses of covered persons will be paid. Complete and proper claims for benefits made by covered persons will be promptly processed but in the event there are delays in processing claims, covered persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

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.

Notice to Plan Participants – HIPAA 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). In general, 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). However, if you or your dependents lose coverage under Medicaid or a state's Children Health Insurance Program (CHIP), or if you or your dependents become eligible for a premium-assistance subsidy under Medicaid or a CHIP, you have 60 days from the loss of coverage or the date of eligibility to request enrollment. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact ASR Health Benefits at (616) 957-1751 or (800) 968-2449.

Your Rights and Protections Against Surprise Medical Bills (Effective July 1, 2022)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is balance billing (sometimes called surprise billing)?

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

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

Surprise billing is an unexpected balance bill that can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for the following:

Emergency services

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

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

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

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

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

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

- You are responsible for paying only your share of the cost (like the co-payments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan must generally do the following:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Labor at (866) 444-3272.

Visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

**Notice of Non-Qualified Health Coverage
for Purposes of Michigan No-Fault Auto Law
(Michigan Residents Only)**

This Notice contains important information that you'll need to know when you purchase or renew an auto insurance policy in the State of Michigan. You should show this Notice to your auto insurance agent so that he or she can help you construct a policy that meets your needs.

Under Michigan no-fault auto law, when you purchase or renew your auto insurance policy you won't automatically receive unlimited, lifetime Personal Insurance Protection (PIP) medical coverage like you have in the past. Instead, you'll be able to choose from a menu of PIP medical coverage levels. Your auto insurance agent will be able to explain the pros and cons of each one

The Andrews University Employee Benefit Plan (the "Plan") doesn't pay any benefits for Michigan enrollees' auto-related claims, and so does not constitute "qualified health coverage" as defined in Michigan Compiled Laws 500.3107d(7)(b)(i). You'll need to make sure that you carry enough PIP medical to protect yourself and your family from financial catastrophe, because that will be your only source of benefits for auto accident-related claims.

Contact your auto insurance agent immediately if you or any of your family members cease to be enrolled in the Plan. An adjustment to your auto policy may be required, and you may have a limited amount of time to make it.

NOTE: This notice is correct at the time of this writing but may not reflect recent changes to plan coverage. For more information, call ASR Health Benefits at (616) 957-1751 or (800) 968-2449.

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

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
Darcy de Leon
4150 Administration Dr.
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.

Information You Need to Know about Medicare Prescription Drug Coverage

- ▶ 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.
- ▶ 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.
- ▶ 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.

Information You Need to Know about Employer's Prescription Drug Coverage

- ▶ 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.

- ▶ 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).

**Notice of Non-Creditable Coverage for High Deductible Health Plan Enrollees
Important Notice about Your Prescription Drug Coverage and Medicare**

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
Darcy de Leon
4150 Administration Dr.
Berrien Springs, Michigan 49104-0840
(269) 471-3871

**Information You Need to Know about the Medicare Prescription Drug Coverage and
Your Current Coverage Under the Health Benefits Plan**

- ▶ 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.
- ▶ 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.
- ▶ 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.
- ▶ 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.**
- ▶ 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 6-30-2023)

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 4150 Administration Drive	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? Darcy de Leon and Raquel Mendoza-Illingworth		
11. Phone number (if different from above) (269) 471 3327 or (269) 471-3886	12. E-mail address darcy@andrews.edu; illingwo@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 mid-year, 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 standard² 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 would 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 Darcy de Leon, the Privacy Officer at Andrews University, at 4150 Administration Dr., Berrien Springs, Michigan 49104-0840, or at darcy@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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/>
<https://www.flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162 Ext. 2131

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

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://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

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.maine.gov/dhhs/ofi/applications-forms>
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/info-details/masshealth-premium-assistance-pa>
Phone: 1-800-862-4840

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

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://dhcnp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
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

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medica/serv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/MedicalHIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlre Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://www.dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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 1/31/2023)

Glossary of Health Coverage and Medical Terms

- This glossary defines 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](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any 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.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

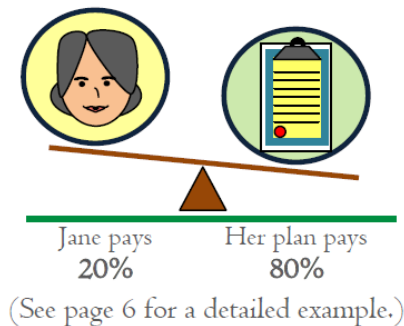
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *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 coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



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 generally aren't complications of pregnancy.

Copayment

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

Cost Sharing

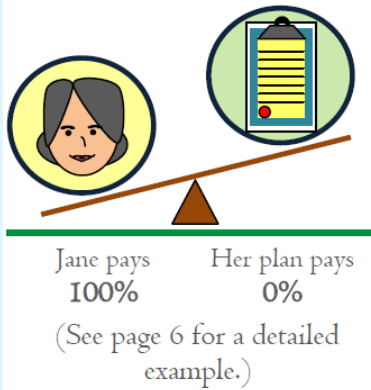
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (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.)



Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

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 a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

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. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

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

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

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 copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

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

Minimum Essential Coverage

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

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 copayments usually are more than [in-network copayments](#).

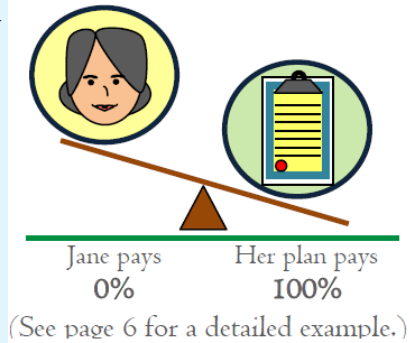
Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Physician Services

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

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) 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.

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.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be 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.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

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.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

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

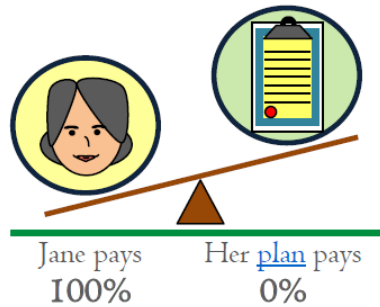
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

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

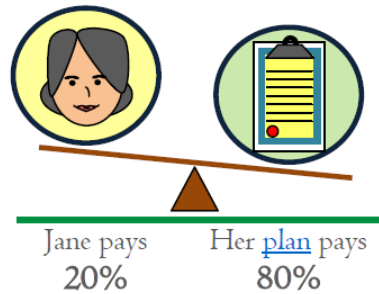
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



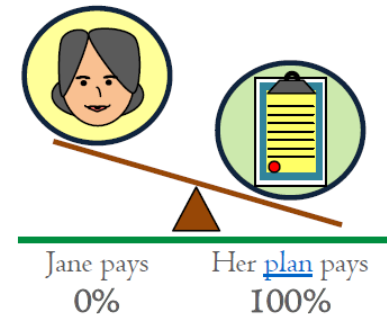
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0



Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: \$125
Jane pays: 20% of \$125 = \$25
Her plan pays: 80% of \$125 = \$100



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: \$125
Jane pays: \$0
Her plan pays: \$125

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