Compliance Document for Albion College, G-6000

Employers offering a self-funded or shared-funded group health plan are responsible to distribute certain notices and perform reporting tasks. This document will help your organization to understand and fulfill these compliance obligations. Where necessary, ASR Health Benefits has inserted your organization's contact information into the notices. If any change to this contact information is necessary, please contact Heather Trevino at (616) 464-3151 or 1-800-968-2449, x3151.

Click on the underlined notice title to jump to the first page of the applicable notice. Once you are done with the notice, press the Home key to return to this page.

Employee Notices and Distribution Recommendations		
Notice Name	**Distribution Recommendation**	
Self-Funded Benefit Plan Notice Click here for detailed notice information.	☒ Open Enrollment; distribution is only required once every five years	☒ New Hire Materials
Women's Health and Cancer Rights Act of 1998 (Also Known As Janet's Law) Click here for detailed notice information.	☒ Open Enrollment	☐ New Hire Materials
Availability of Notice of Privacy Practices Click here for detailed notice information.	☒ Open Enrollment; distribution is only required once every three years	☐ New Hire Materials
Notice of HIPAA Special Enrollment Rights Click here for detailed notice information.	☐ Open Enrollment ☒ Other: ASR includes this notice automatically on the ASR enrollment form. Distribute this notice if the ASR enrollment form is not used.	☐ New Hire Materials
Surprise Billing Notice Click here for detailed notice information.	☒ Open Enrollment	☒ New Hire Materials
Michigan No-Fault Notice Click here for detailed notice information.	☒ Open Enrollment; distribute to Michigan residents only	☒ New Hire Materials; distribute to Michigan residents only
Notice(s) of Creditable or Non-Creditable Coverage for Medicare Part D Click here for detailed notice information.	☒ Open Enrollment ☒ Other: Annual distribution also required **before October 15**	☒ New Hire Materials
Health Insurance Marketplace Coverage Options and Your Health Coverage Click here for detailed notice information.	☐ Open Enrollment	☒ New Hire Materials; must be provided within 14 days of hire

Revised 11/15/24

Employee Notices and Distribution Recommendations	
Notice Name	**Distribution Recommendation**
Notice of Privacy Practices Click here for detailed notice information.	☐ Open Enrollment ☒ New Hire Materials ☒ Other: Distribute upon request
Illinois' Consumer Coverage Disclosure Act (CCDA): Comparison of Essential Health Benefit Coverage Click here for detailed notice information.	☒ Annually (distribute at open enrollment to Illinois employees only) ☒ New Hire Materials; distribute to Illinois employees only ☒ Other: Distribute upon request to Illinois employees only
Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP) Click here for detailed notice information.	☒ Open Enrollment ☒ New Hire Materials ☒ Other: Distribute to all employees
Glossary of Health Coverage and Medical Terms Click here for detailed notice information.	☐ Open Enrollment ☐ New Hire Materials ☒ Other: Distribute upon request

ASR Privacy Policy Notice, Mental Health Parity Comparative Analysis, and Other Information (No Distribution Required Unless Noted)

Privacy Policy for Self-Funded and Shared-Funded Group Plans

This notice is the ASR Health Benefits Privacy Policy for Self-Funded and Shared-Funded Group Plans, which is being provided in compliance with the Gramm-Leach-Bliley Act (GLBA). ASR must provide this notice annually to your organization. This notice does not need to be distributed to employees.

Mental Health Parity Comparative Analysis

The Consolidated Appropriations Act, 2021 (CAA) requires Plan Sponsors / Plan Administrators to perform a comparative analysis of non-quantitative treatment limitations that apply to mental health and substance use disorder benefits when compared to other medical/surgical benefits. ASR has performed this analysis on your Plan's behalf. You can access, view, and download this comparative analysis via our Website at www.asrhealthbenefits.com using your organization's Employer login credentials. Once logged in, the item is saved under Resources/Documents/Plan Documents and is entitled MHP Comparative Analysis.

Your organization must provide a copy of this comparative analysis document upon request to state insurance regulators, the Secretary of Labor, the Secretary of Health and Human Services, or the Secretary of the Treasury. This comparative analysis document does not need to be distributed to employees.

U.S. Department of Labor Distribution Guidelines for Plan Materials

This appendix document includes details about legal guidelines for print or electronic distribution of items such as legally required notices, benefit summaries, and the Summary Plan Description. This appendix document does not need to be distributed to employees. Click here for more information about print or electronic distribution.

ASR Privacy Policy Notice, Mental Health Parity Comparative Analysis, and Other Information (No Distribution Required Unless Noted)

CMS Annual Disclosure Requirement Information

Your organization must provide prescription drug coverage information to the Centers for Medicare and Medicaid Services (CMS) regarding your prescription drug coverage at the following times:

1. Annually, on or before March 2, 2025.
2. Within 30 days after any change in the creditable coverage status of the prescription drug plan.
3. Within 30 days after the termination of the prescription drug plan.

Access the disclosure form at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html to fulfill your organization's disclosure requirement. The Disclosure to CMS Form is generally required to be submitted online and not in hard copy. However, if you lack Internet access, you may fax a hard copy upon request.

Wellness Program Notice Information and Authorization Requirements

If your organization offers a wellness program that includes a Health Risk Assessment or biometric screening, a notice must be given to employees. The Equal Employment Opportunity Commission provides a model notice for this purpose on its Website: https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm. Please follow this link and create a separate notice document using the current published notice text as needed. This notice must be distributed to employees before they provide any health information and within enough time for them to decide whether to participate in the program. The notice must describe what information will be collected as part of the wellness program, who will receive it, how it will be used, and how it will be kept confidential. If spouses are required to provide information about the manifestation of disease or disorder under the wellness program, they must provide prior, knowing, written, and voluntary authorization.

If your organization does not offer a wellness program, or if it offers a wellness program that does not include a Health Risk assessment or biometric screening, this notice is not required.

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 Albion College Group Health Plan (the "Plan"). Currently, the following self-funded benefits are offered under the Plan: medical and prescription drug. 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 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 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.

ASR

Your Rights and Protections Against Surprise Medical Bills

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 balance billing. In these cases, you shouldn't be charged more than your plan's co-payments, coinsurance, or deductible.

What is balance billing (sometimes called surprise billing)?

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

Out-of-network means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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, coinsurance, and deductibles). 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 balanced billed for these post-stabilization services.

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This 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 types of 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 these 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 any additional costs to 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 (also known as prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, contact the No Surprises Helpdesk at (800) 985-3059.

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

Notice of 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.

Under Michigan no-fault auto law, when you purchase or renew your auto insurance policy you're able to choose from a menu of Personal Insurance Protection (PIP) medical coverage levels. When considering how much PIP medical coverage to purchase, it's critical to keep these points in mind:

- **Albion College's health plan (the "Plan") pays primary on Michigan enrollees' auto-related claims, and given current deductible requirements constitutes "qualified health coverage" as defined in Michigan Compiled Laws 500.3107d(7)(b)(i).**
- Coverage of auto accident-related claims under any employment-based plan is available only as long as you remain employed/enrolled AND that plan continues to cover Michigan enrollees' auto claims. In contrast, the amount of PIP medical coverage on your policy at the time of an auto accident remains available to you until the maximum payout per accident (if any) is exhausted, no matter how long that takes.
- Most types of care are covered under both the Plan and PIP medical. However, PIP medical covers additional services that employment-based plans typically do not. Your auto insurance agent can explain what those services are.

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 has been prepared for general distribution purposes only. To request the personalized paperwork that you will need to purchase or renew your auto insurance, call ASR Health Benefits at (616) 957-1751 or (800) 968-2449 or send an e-mail message to auto_cob_request@asrhealthbenefits.com. The e-mail request must contain the name and telephone number of the employee or family member who's making the request, the Group # from the front of the ID card, and the ID # from the front of the ID card. The request must also specify whether the paperwork should be sent by mail, or by e-mail.

Notice of Creditable Coverage for
Plan 1 PPO Plan and Plan 2 PPO 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 Albion College (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:

Albion College
Stacey Hobart, Human Resources
611 E. Porter St
Albion, MI 49224
(517) 629-0196

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 Plan 1 HDHP/HSA Plan and Plan 2 HDHP/HSA 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 Albion College (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:

Albion College
Stacey Hobart, Human Resources
611 E. Porter St
Albion, MI 49224
(517) 629-0196

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 <u>NOT</u> 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.
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).

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum-value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum-value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum-value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum-value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum-value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.
Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum-value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your health plan's 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.

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 Albion College	**4. Employer Identification Number (EIN)** 93-0242990	
5. Employer address 611 E. Porter St	**6. Employer phone number** (517) 629-0205	
7. City Albion	**8. State** MI	**9. ZIP code** 49224
10. Who can we contact about employee health coverage at this job? Stacey Hobart		
11. Phone number (if different from above) (517) 629-0196	**12. E-mail address** shobart@albion.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 working in full-time employment for 30 hours or more per week. Such individuals must complete any required waiting period for plan coverage 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.
    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** will guide you through the process. Here's the employer information you'll enter when you visit **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 standard[3]?

☐ 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 standard[2]. (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

[3]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 Albion College (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 January 1, 2024. If you have any questions about this notice, please contact Stacey Hobart, the Privacy Officer at Albion College, at 611 E. Porter St, Albion, MI 49224, or at shobart@albion.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.

<u>Special Situations</u>. 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).

<u>Rights Regarding Health Information</u>. 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.

Illinois' Consumer Coverage Disclosure Act (CCDA): Comparison of Essential Health Benefit Coverage
Prepared by ASR Health Benefits

Employer/Plan Administrator: Albion College, G-6000

Employer State of Situs: Michigan

Employer Plan Name: Albion College Group Health Plan

Plan Year: January 1, 2025 through December 31, 2025

Category	Service	Covered Under the Employer Plan?
Ambulatory Patient Services	Accidental Injury – Dental	Yes, partially[1]
	Allergy Injections and Testing	Yes
	Bone-Anchored Hearing Aids	Yes, partially[2]
	Durable Medical Equipment	Yes
	Hospice Care	Yes
	Infertility Treatment	Yes, partially[3]
	Outpatient Surgery (Surgeon, Anesthesia, Facility)	Yes[4]
	Private-Duty Nursing	Yes
	Prosthetics & Orthotics	Yes
	Sterilization (Men)	Yes
	Temporomandibular Joint Disorder ("TMJ")	Yes

Category	Service	Covered Under the Employer Plan?
Emergency Services	Emergency Room Services (Includes Mental Health/Substance Use Disorders)	Yes

Category	Service	Covered Under the Employer Plan?
Emergency Services, cont'd	Emergency Transportation / Ambulance	Yes

Category	Service	Covered Under the Employer Plan?
Hospitalization	Bariatric Surgery (Obesity)	Yes, partially[5]
	Breast Reconstruction after Mastectomy	Yes
	Reconstructive Surgery	Yes
	Inpatient Hospital Services	Yes
	Skilled Nursing Facility	Yes
	Human Organ Transplants (Including Transportation & Lodging)	Yes

Category	Service	Covered Under the Employer Plan?
Diagnostic Services	X-rays, Lab Tests, EKGs, etc.	Yes

Category	Service	Covered Under the Employer Plan?
Mental Health / Substance Use Disorders	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	Yes
	Mental Health Treatment (Including Inpatient)	Yes[6]
	Opioid Medically Assisted Treatment (MAT)	Yes
	Substance Use Disorder Treatment (Including Inpatient)	Yes
	Tele-Psychiatry	Yes[6]
	Topical Anti-Inflammatory Acute and Chronic Pain Medication	Yes

Category	Service	Covered Under the Employer Plan?
Pediatric Oral and Vision Care	Pediatric Dental Care	Yes, partially[7]
	Pediatric Vision Care	Yes, partially[8]

Category	Service	Covered Under the Employer Plan?
Pregnancy, Maternity, and Newborn Care	Maternity Services	Yes

Category	Service	Covered Under the Employer Plan?
Outpatient Prescription Drugs	Outpatient Prescription Drugs	Yes, partially[3, 9]

Category	Service	Covered Under the Employer Plan?
Preventive and Wellness Services	Colorectal Cancer Examinations & Screenings	Yes
	Contraception / Birth Control Services	Yes
	Diabetes Self-Management Training and Education	Yes
	Diabetic Supplies	Yes
	Mammogram Screenings	Yes
	Osteoporosis – Bone Mass Measurement	Yes
	Cervical Cancer Screenings	Yes
	Prostate-Specific Antigen Tests	No
	Ovarian Cancer Surveillance Tests	Yes
	Preventive Care Services (In General)	Yes
	Sterilization (Women)	Yes

Category	Service	Covered Under the Employer Plan?
Rehabilitative and Habilitative Services and Devices	Chiropractic and Osteopathic Manipulation	Yes, partially[10]
	Habilitative and Rehabilitative Services	Yes, partially[6,11]

Comment Key

1. Employer Plan's coverage limited to treatment rendered within six months of the accident.
2. Employer Plan covers only the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage is in effect.
3. Employer Plan covers charges for the diagnosis and treatment of the underlying cause of infertility or sterility, but does not cover charges related to the restoration or enhancement of fertility (including any artificial means of achieving pregnancy or ovulation), or charges for drugs prescribed to treat infertility.
4. Employer Plan does not cover certain oral surgeries if those services are covered under the employer's dental plan (if any).
5. Employer Plan requires that criteria be met in order for bariatric surgery to be covered. Employer Plan's coverage limited to one bariatric surgery per person in a lifetime.
6. Employer Plan does not cover treatment of Autism Spectrum Disorder, except for eligible prescription drugs prescribed to treat a Mental Illness or Disorder or a Functional Nervous Disorder (as those terms are defined in the Employer Plan).
7. Employer Plan's coverage limited to preventive care services mandated by health care reform. Additional benefits may be available through a separate dental plan.
8. Employer Plan's coverage limited to preventive care services mandated by health care reform. Additional benefits may be available through a separate vision plan.
9. Employer Plan may cover some medications under the medical aspect of the plan, and some medications under the Prescription Drug Benefit.
10. Employer Plan's coverage limited to 24 visits per Plan Year for chiropractic care. This maximum does not include visits where only x-rays were taken and no other services were rendered.
11. Employer Plan's coverage limited to 60 visits per Plan Year for all chiropractic care, physical therapy, occupational therapy, and speech therapy combined.

For more information about the CCDA visit https://www2.illinois.gov/idol/Laws-Rules/FLS/Pages/Consumer-Coverage-Disclosure-Act.aspx or contact Paige Eaton at ASR Health Benefits by phone ((616) 464-6023) or e-mail (paigee@asrhealthbenefits.com).

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, 2024. Contact your state for more information on eligibility.

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162, Press 2

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

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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

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

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

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

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

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

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

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

VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Websites: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

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

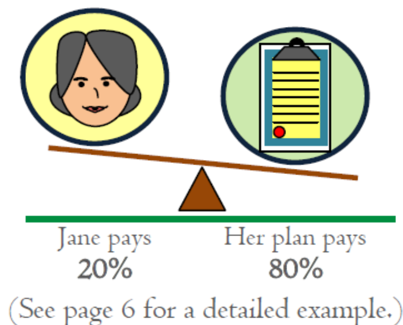
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $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.)



(See page 6 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 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

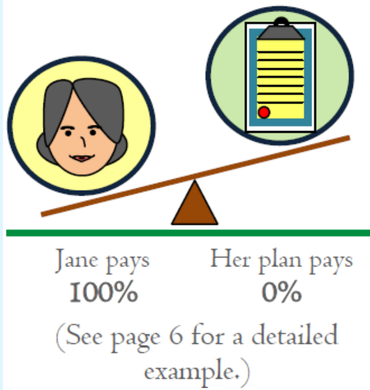
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your 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.)



(See page 6 for a detailed example.)

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.

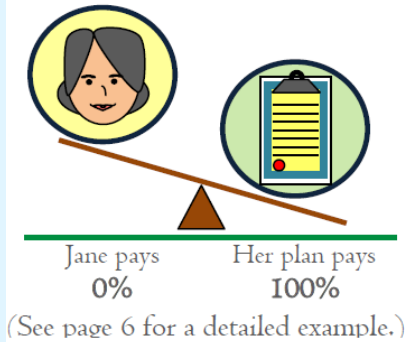
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

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.



(See page 6 for a detailed example.)

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.

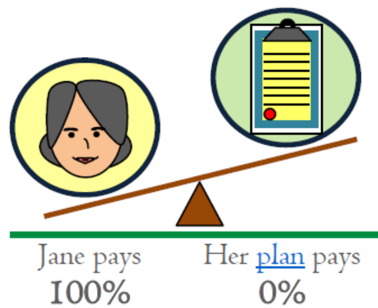
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

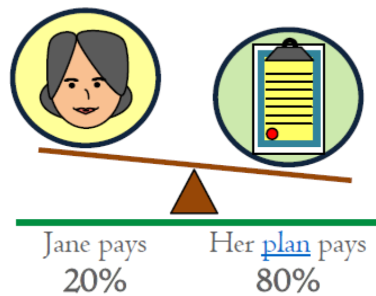
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

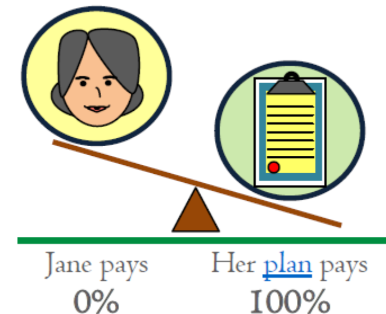
December 31st
End of Coverage Period



Jane pays 100% | Her plan pays 0%



Jane pays 20% | Her plan pays 80%



Jane pays 0% | Her plan pays 100%

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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Privacy Policy for Self-Funded and Shared-Funded Group Plans

This policy explains how ASR Health Benefits collects nonpublic personal information, the type of information that we may collect, and what information we may disclose to other companies not affiliated with ASR Health Benefits.

Acquisition of Personal Information

We collect nonpublic personal information about the individual participants of group plans, which the employers/plan sponsors and health care providers afford us.

Categories of Information We Disclose

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. For example, we only disclose nonpublic personal information when it is related to a request or transaction from the employer/plan sponsor, where authorized by the participant, or where required by law.

Parties to Whom We Disclose Information

We only permit disclosure of nonpublic personal information to our employees who are working on clients' accounts and to unrelated third parties who need to know that information in order to assist us in providing services to clients.

Confidentiality and Security of Nonpublic Personal Information

We restrict access to nonpublic personal information to those individuals who need to know that information in order to provide services or products for the policy. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to secure nonpublic personal information.

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, but no less than one year from the date they were first posted on the Website.

If plan materials are distributed via e-mail, we suggest the following measures to comply with HIPAA Privacy guidelines: (1) conceal the recipient e-mail addresses using the blind-courtesy-copy (Bcc) function; (2) e-mail the materials to all employees, even if they do not participate in the plan; or (3) e-mail the materials to each participant individually. Since these e-mails identify employees as enrolled in a health plan, they should be encrypted if sent outside your organization.

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 outlined 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 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-viii.pdf 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.

Appendix B: Additional Notice Information

Self-Funded Benefit Plan Notice

Michigan Compiled Laws 550.932 (Michigan's Third Party Administrator Act) requires that a written notice with specific information be distributed to all new enrollees in the self-funded group benefit plan at the time of enrollment (but no later than 60 days after becoming covered), and to all plan participants at least once every five years. ASR recommends that this notice be attached to a comprehensive and current benefit description of the self-funded plan, such as an ASR-prepared benefit summary handout or, if available, a Summary of Benefits and Coverage (SBC). To facilitate our clients' compliance efforts, the required notice content is included in all Summary Plan Descriptions (SPD) drafted by ASR. A separate distribution of this notice will only be required if the ASR-drafted SPD is not used or if the SPD is not distributed at the time of enrollment or every five years.

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

A copy of the Department of Labor's model notice, which must be distributed yearly to all plan participants. The annual notice may be given at any time during the year, and it is not required for the plan year during which a covered person is enrolled and receives notice via the benefits booklet.

Availability of the Notice of Privacy Practices

A copy of a model notice, which must be distributed at least once every three years to all plan participants. The name of the Privacy Officer or Human Resources Director may be inserted where appropriate. This notice may be given at any time during the year.

Notice of HIPAA Special Enrollment Rights

A copy of the model notice, which must be distributed any time an employee is initially offered the opportunity to enroll in the health plan. While there is no annual redistribution requirement associated with this notice, ASR recommends providing it to all enrollees upon an individual's initial enrollment in the plan and during the annual open enrollment period. To facilitate our clients' compliance efforts, the required notice content is automatically included on the ASR-provided enrollment form. A separate distribution of this notice will only be required if the ASR-provided enrollment form is not used.

Surprise Billing Notice

A copy of the "version two" model notice that describes protections against "balance billing" (sometimes called "surprise billing"). ASR recommends providing it to all enrollees upon an individual's initial enrollment in the plan and during the annual open enrollment period.

Michigan No Fault Notice

This notice specifies whether or not the plan constitutes Qualified Health Coverage as that term is defined under Michigan no-fault law, and is used when an enrollee who resides in Michigan purchases or renews a personal automobile insurance policy. We have made the Qualified Health Coverage determination on your organization's behalf based on criteria developed by the Michigan Department of Insurance and Financial Services (DIFS). In order to be Qualified Health Coverage, the medical plan cannot exclude or limit coverage for Michigan residents' automobile accident claims, and must have an in- or out-of-network individual deductible that is $6,579 or less. As Plan Sponsor, you are ultimately responsible for the accuracy of the determination issued to your enrollees. If you believe that an inaccurate determination has been made on your behalf, please contact our office.

Notice(s) of Creditable or Non-Creditable Coverage for Medicare Part D

Medicare Part D requires employers sponsoring group health plans that provide prescription drug coverage to distribute a notice of creditable or non-creditable prescription drug coverage to Medicare-eligible enrollees annually before October 15 for retirees or other individuals eligible for Medicare because of disability, age, or end-stage renal disease. You must also provide a notice of creditable or non-creditable coverage upon an individual's initial enrollment in the plan, upon an individual's request, and at any time the coverage changes in a way that causes it to switch from creditable to non-creditable, or vice versa. If you offer more than one level of prescription drug coverage (e.g., different co-payment amounts linked to different election offerings), the creditable/non-creditable determination must be made for each coverage level.

If a covered person switches plan options during the annual open enrollment period or mid-year after experiencing a HIPAA special enrollment right and this enrollment change causes his or her prescription drug coverage to switch from being creditable to non-creditable or vice versa, the corresponding notice of creditable or non-creditable prescription drug coverage should be provided to the covered person upon their enrollment in the new plan option.

We have made an initial determination on your organization's behalf whether your prescription drug coverage is creditable or non-creditable. This determination was made based on the Creditable Coverage Simplified Determination criteria developed by the Centers for Medicare and Medicaid Service (CMS), which can be viewed at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CCSimplified091809.pdf. As Plan Sponsor, you are ultimately responsible for the accuracy of the determination issued to your enrollees. You are strongly encouraged to review this information and develop your own determination. In the event you believe that an inaccurate determination has been issued on your behalf, please contact our office.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PPACA requires employers to notify their employees of health coverage options that are available through the Health Insurance Marketplace. Employers must deliver the notice to new employees within 14 days of the date of hire. Though current guidelines do not mandate redistribution for all employees on an annual basis or when the notice is modified, ASR recommends that if changes have been made to the notice, the updated notice be redistributed to employees at the employer's earliest convenience.

Employers must provide a notice to all full-time and part-time employees, regardless of whether the employee is enrolled in an employer-sponsored medical plan or eligible to enroll in the plan. The notice does not have to be provided to employees' dependents, nor does it have to be provided to former employees.

ASR has inserted some basic information about the health coverage offered by your organization on page three of the notice. Please carefully review page three for accuracy and contact our office if any change to the information is necessary. **Please also note that completing the section on page four is an optional choice for your organization**. Page four of the notice must be distributed even if your organization does not complete the section.

We have made an initial determination on your organization's behalf whether or not your plan option(s) meet the minimum-value standard established under PPACA by using the Minimum Value Calculator provided by HHS and the IRS, which can be downloaded from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html. In addition to certifying that the plan option meets the minimum-value standard, your organization must also advise employees whether or not the coverage provided is affordable via this notice. Employer-provided health insurance coverage is deemed unaffordable if the premium required to be paid by the employee exceeds 9.5% of the employee's household income. The IRS has proposed a safe harbor determination under which affordability may be determined on the basis of an employee's income reported on his or her Form W-2 (Box 1). As Plan Sponsor, you are ultimately responsible for the accuracy of the determination issued to your employees, and ASR does not have the necessary information to assist your organization with the affordability determination. In the event you believe that an inaccurate determination has been made on this notice, please contact our office.

Employers that are not subject to the "Fair Labor Standards Act" (FLSA) are not legally required to distribute this notice. For assistance in determining whether or not your organization is subject to the FLSA, please visit https://webapps.dol.gov/elaws/whd/flsa/scope/screen24.asp.

Notice of Privacy Practices

A copy of a model notice, which must be distributed to any plan participants upon request and to new hires. ASR has inserted the name of your Privacy Officer into the introductory paragraph of the Notice of Privacy Practices. This notice describes how the plan may use and disclose an individual's protected health information, explains an individual's rights with respect to the information and how the individual may exercise these rights, explains the plan's legal duties with respect to the individual's protected health information, and provides information for an individual who can be contacted for additional information about the plan's privacy policies.

Illinois' Consumer Coverage Disclosure Act (CCDA): Comparison of Essential Health Benefit Coverage

Employers are required to give benefit-eligible employees residing in the state of Illinois a tool that explains how the plan's coverage of some common health care services compares with the coverage provided by the Benchmark health insurance policy available for purchase on the Health Insurance Marketplace. ASR has prepared this coverage comparison tool (notice) on your organization's behalf. This notice should be provided to all employees residing in Illinois who are eligible for plan coverage (whether or not such coverage is elected), and should be distributed when the employee is initially hired, annually each year (e.g., included with the Plan's annual open enrollment materials), and at any time upon request. As an alternative to providing a paper copy of the notice, employers may distribute this notice electronically via e-mail or by posting the information on a Website that employees can regularly access.

By law, an employer must keep documentation that each benefit-eligible employee residing in the state of Illinois has received the comparison notice for a period of at least one year.

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

A copy of a model notice, which must be distributed annually to all employees (including employees who are not currently participating in your organization's group health plan) who reside in a state providing a premium assistance subsidy. This notice should also be included in enrollment materials given to newly hired employees. A list of states providing such a subsidy is included in the model notice. Michigan does not currently provide a premium assistance subsidy to its residents. However, even if the majority of your employees reside in Michigan, you still need to distribute this notice to a dependent child or COBRA participant who moves out-of-state. Employees must receive this notice before the start of the plan year.

Glossary of Health Coverage and Medical Terms

A copy of the Glossary of Health Coverage and Medical Terms, a companion document to the latest universal Summary of Benefits and Coverage (SBC) document, required for group health plans under the Patient Protection and Affordable Care Act. The purpose of this glossary is to help individuals better understand their health coverage, as well as other coverage options. This glossary is referenced in the first paragraph on page 1 of the SBC and your organization must provide a paper copy of the glossary to any individual eligible for plan coverage upon request only (i.e., there is no periodic distribution requirement for this item). Your organization can also access a copy of the glossary on our Website at www.asrhealthbenefits.com.