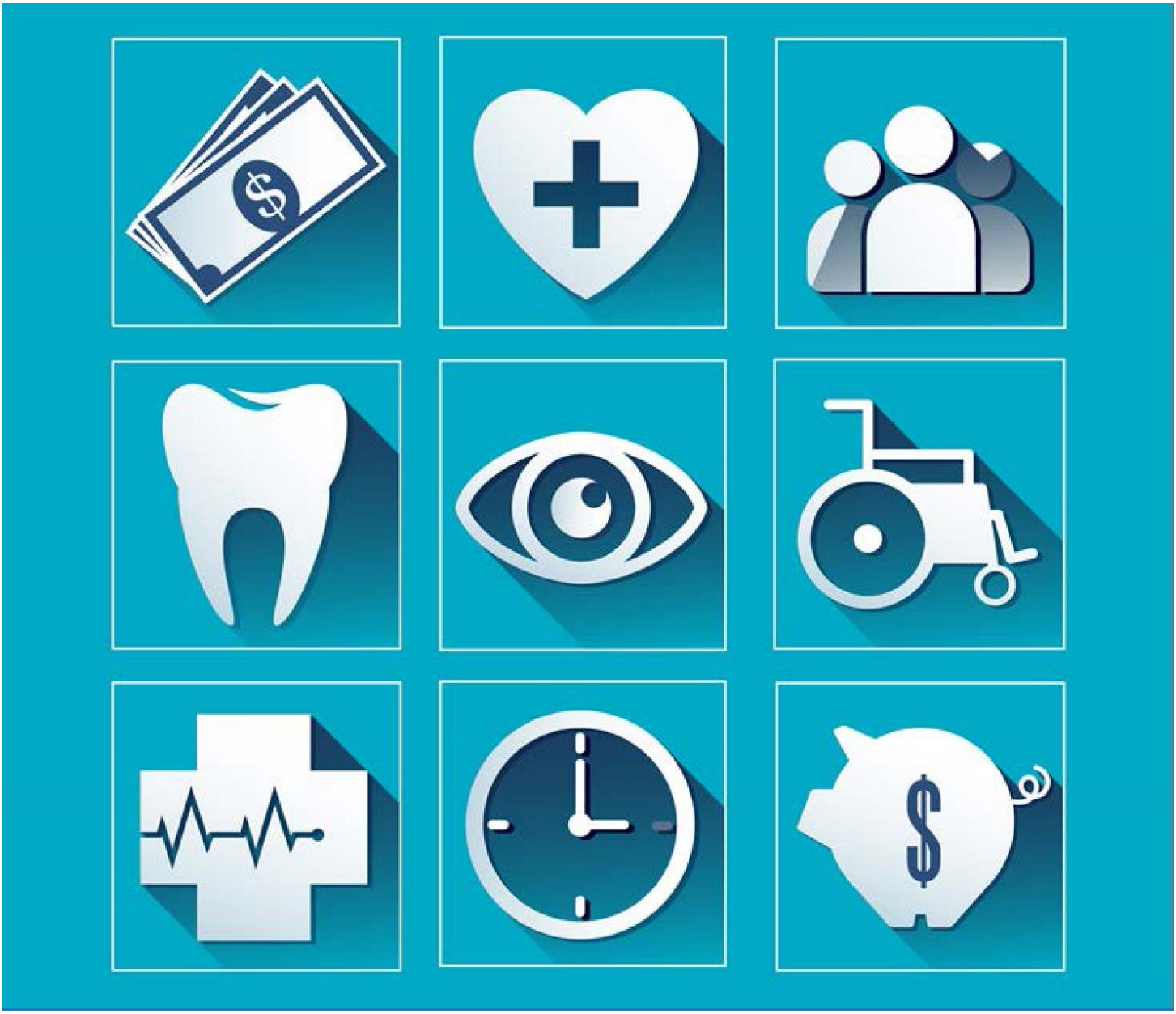
Albion College

Employee Benefits Enrollment Guide

Plan Year: 07/01/2018 – 06/30/2019



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Who is Eligible?

You are eligible to enroll into the Albion College sponsored employee benefit programs if you are;

An active Executive Staff, Faculty or Administrative Employee regularly working at least 32 hours each week, OR

A Facilities Employee subject to a Collective Bargaining Agreement and regularly working at least 25 hours per week, OR

An Active Secretarial or Clerical Employee subject to a Collective Bargaining Agreement and regularly working at least 21 hours per week.

How to Enroll

The first step is to review your current benefit elections. Verify your personal information and make any changes, if necessary. Make your benefit elections, if necessary. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Please reference Page 10 of this document for specific instructions on which forms to complete.

When to Enroll

The Albion College Open Enrollment period is 05/01/2018 – 05/31/2018. The medical, dental and vision benefits you select during the open enrollment period will be effective from **July 1, 2018 through June 30, 2019**

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. *Qualified changes in status include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partner's benefits or employment status*.

You are required to notify and submit any qualified enrollment changes to HR within 30 days of the event date.

Medical and Prescription Drug Insurance

Albion College is proud to offer you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. While medical insurance costs continue to increase, we will remain with Blue Cross Blue Shield of Michigan (BCBSM) for the 2018 – 2019 plan year and continue offering two plan options. Deductibles and Out-of-Pocket Max run January – December.

- To find a BCBSM network provider visit www.bcbsm.com
- To register as an employee and access additional information, visit www.bcbsm.com
- You may also call BCBSM at (877) 354-2583 and reference the group and membership number on your ID card

Services	Blue Cross Blue Shield of Michigan	
	Community Blue PPO Plan 0002	**Community Blue PPO Plan 0003**
Deductible - Individual - Family	***In-Network / Out-of-Network*** $500 / $1,000 $1,000 / $2,000	***In-Network / Out-of-Network*** $1,500 / $1,000 $3,000 / $2,000
Co-Insurance	80% / 60%	80% / 60%
Annual Co-Insurance Max -Individual -Family	$500 / $1,500 $1,000 / $3,000	$500 / $1,500 $1,000 / $3,000
Annual Out-of-Pocket Max - Individual - Family	$6,350 / $12,700 $12,750 / $25,400	$6350 / $12,700 $12,700 / $25,400
Office Visit - Primary Care - Specialty Care	$20 Copay / Ded & Co-Ins $20 Copay / Ded & Co-Ins	$20 Copay / Ded & Co-Ins $20 Copay / Ded & Co-Ins
Preventive Care - Health Maintenance Exam - Annual Gynecological Exam - Pap Smear Screening - Well Baby & Child Care Visits - PSA Screening	$0 Copay / Not Covered One/ member/ calendar year One/ member/ calendar year One/ member/ calendar year Scheduled according to age One/ member/ calendar year	$0 Copay / Not Covered One/ member/ calendar year One/ member/ calendar year One/ member/ calendar year Scheduled according to age One/ member/ calendar year
Mammography Screening	$0 Copay / 60% after deductible One/ member/ calendar year	$0 Copay / 60% after deductible One/ member/ calendar year
Emergency Room	$50 Copay, then Co-Insurance	$50 Copay, then Co-Insurance
Hospital Services - Outpatient - Inpatient	80% after deductible / 60% after deductible 80% after deductible / 60% after deductible	80% after deductible / 60% after deductible 80% after deductible / 60% after deductible
Mental Health Treatment - Outpatient - Inpatient (Unlimited Days)	80% after deductible / 60% after deductible 80% after deductible / 60% after deductible	80% after deductible / 60% after deductible 80% after deductible / 60% after deductible
Additional Services - Chiropractic Manipulation (24 visit maximum/year) - PT / OT / ST (60 visit maximum/year)	$20 Copay/ 60% after deductible 80% after deductible / 60% after deductible	$20 Copay/ 60% after deductible 80% after deductible / 60% after deductible
Prescription Drugs - Tier 1: Generic - Tier 2: Formulary Brand - Tier 3: Non-Formulary Brand	Retail – 30 days / Mail Order – 90 days $10 Copay $20 Copay $40 Copay	Retail – 30 days / Mail Order – 90 days $10 Copay $40 Copay $40 Copay

Your Monthly Medical and Rx Cost *(dental rates provided on page 6)*

2018 – 2019 Employee Rates with Discounts									
Salary/Wage Amount		Employee Discount	Employee Monthly Premium						
2018-2019 Dollar Amount			Plan 002 – Community Blue PPO Medical and Rx Cost $500/$1,000 Deductible				Plan 003 – Community Blue HD PPO Plan 003 Medical and Rx Cost $1,500/$3,000 Deductible		
			$1,532.00	**$1,855.00**	**$1,855.00**		**$1,290.00**	**$1,611.00**	**$1,611.00**
At Least	**But Under**	**2018 - 2019**	$873.00	$1,196.00			$631.00	$952.00	
			EE + 1	**Family**	**2 EE Family**		**EE + 1**	**Family**	**2 EE Family**
$0	**$64,200**	50%	$436.50	$598.00	$268.50		$315.50	$476.00	$146.50
$64,200	**$89,880**	40%	$523.80	$717.60	$322.20		$378.60	$571.20	$175.80
$89,880	**$115,560**	30%	$610.10	$837.20	$375.90		$441.70	$666.40	$205.10
$115,560	**$141,240**	20%	$698.40	$956.80	$429.60		$504.80	$761.60	$234.40
$141,240	---	10%	$785.70	$1,076.40	$483.30		$567.90	$856.80	$263.70

TeleHealth & Online Health Care

Albion College will continue providing Blue Cross Online Visits offered through Blue Cross Blue Shield of Michigan. You can use this option when it's convenient for you and you want fast, easy, affordable, quality care. You may want to use online health care when: your doctor's office is closed; you feel too sick to drive; you have children at home and can't leave; you're traveling or on vacation. Many minor, non-emergent conditions may be treated online, e.g., sinus and respiratory infections; colds, flu and seasonal allergies; urinary tract infections; vomiting; diarrhea; headache; strains and sprains; pinkeye; rashes; skin wounds. You should not use online healthcare as a substitute for regular maintenance of chronic medical conditions, emergencies and serious or life threatening conditions.

Most doctor visits take about 10 minutes and *costs you nothing*. Doctors can review your history, answer questions, diagnose, treat and even prescribe medication. Prescriptions will be sent to your pharmacy of choice.

When your doctor isn't available, you can connect to Blue Cross Online Visits by:

Mobile: Download the BCBSM Online Visits app
Web: Visit www.bcbsmonlinevisits.com
Phone: Call (844) 606-1608

Dental Insurance

There are no plan changes to your dental benefits for the 2018 - 2019 plan year, the dental plan will continue to be a stand-alone benefit, not tied to your medical plan election, which will require a separate coverage election. The plan will continue to allow you to seek treatment from the dentist of your choice. Deductibles run January – December.

- To find a BCBSM network provider visit www.mibluedentist.com
- To register as an employee and access additional information, visit www.bcbsm.com
- You may also call BCBSM at (877) 354-2583 and reference the group and membership number on your ID card

Services	Blue Cross Blue Shield of Michigan Dental PPO
Deductible - *waived for preventive* - Individual - Family	$100 $200
Type I - Preventive Care - Oral exams - Teeth cleaning - Bitewing x-rays - Full mouth x-rays - Flouride Treatments - Space Maintainers	90%
Type II - Basic Services - Fillings (amalgam, acrylic or silicate) - Root canal therapy - Periodontic treatments - Palliative (emergency) treatment - General anesthesia - Oral surgery including extractions	90%
Type III - Major Services - Removable dentures - Inlays, onlays and crowns - Fixed Bridges	50%
Annual Maximum Benefit *Type I, II and III services combined*	$1,000
Orthodontia - Minor tooth guidance appliances - Full-banding treatment - Monthly, active treatment visits **Lifetime Orthodontia Maximum** *Coverage for Children up to age 19*	50% $1,000

Your Monthly Dental Cost

Dental PPO	Single	Plus 1	Family	2 EE Family
	$0.00	$40.50	$59.40	$32.40

Vision

Enrollment in the VSP Vision Plan is optional and 100% paid for by employees. If you utilize the services of a VSP provider listed in the Preferred Provider Directory, your benefits include routine vision exams for a $10 copay, and preferred pricing on a large selection of brand-name, designer frames, lenses, and lens options.

To Find a VSP provider, visit www.vsp.com or call (800) 877-7195. At your appointment, tell them you have VSP. There's no ID card necessary and no claim forms to complete if you see a VSP provider. If you prefer to have a card, one can be downloaded from the www.VSP.com site.

Services	VSP Signature Network *(Your coverage with a VSP provider)*		
	Description	**Copay**	**Frequency**
Eye Exam	Focuses on your eyes and overall wellness	$10 Copay	Every 12 months
Prescription Glasses		$25 Copay	See Frames & Lenses
Frames	○ $130 allowance for a wide selection of frames ○ $150 allowance for featured frame brands ○ 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 24 months
Lenses	○ Single vision, lined bifocal and lined trifocal lenses ○ Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	○ Scratch resistant coating ○ Standard progressive lenses ○ Premium progressive lenses ○ Custom progressive lenses ○ Average savings of 35-40% on other lens enhancements	$0 $50 $80 - $90 $120 - $160	Every 12 months
Contact Lenses *(in lieu of glasses)*	○ $130 allowance for contacts; copay does not apply ○ Contact lens exam (fitting & evaluation)	Up to $60	Every 12 months

Your Monthly Cost

	Single	2 person	Family
VSP Signature PPO	$7.80	$11.90	$21.34

Group Life Insurance

Albion College provides full-time salaried and union employees with employer paid group life and accidental death and dismemberment (AD&D) insurance, offered through The Standard.

Full-time Executive, Faculty and Administrative employees are eligible for a benefit equivalent to 2 times your annual earnings.

For Union employees covered by a collective bargaining agreement, your life insurance benefit under the current contract is $50,000.

If necessary, please be sure to contact Human Resources to update your beneficiary.

Short-Term Disability Income Benefits

Albion College provides union employees covered by a collective bargaining agreement with short-term disability income benefits, offered through The Standard, and pays the full cost of this coverage. In the event you become disabled from a non-work related injury or sickness, you may be eligible to receive disability income benefits following a 15- day elimination period, for a maximum of 26 weeks.

Under the current contract, maximum benefit amounts are as follows:

- Class 1 – Trades: Up to $300/ week
- Class 2 – Secretarial/Clerical >35 hrs: Up to $300/ week
- Class 3 – Secretarial/Clerical 21 to 35 hrs: Up to $180/ week

Full-time Executive, Faculty and Administrative employees are covered by a self-administered salary continuation plan. For a description of the plan please reference: http://bit.ly/23p6arb

You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Long-Term Disability Income Benefits

Albion College provides full-time salaried and union employees with long-term disability income benefits, offered through The Standard, and pays the full cost of this coverage. You are eligible for long-term disability benefits the first of the month following 12 consecutive months of employment.

In the event you are disabled from a non-work related injury or sickness and have satisfied a 180-day elimination period, you may be eligible to receive disability income benefits equivalent to 60% of your monthly earnings, not to exceed $7,500/ month. Benefits are payable up to age 65 unless the disability begins on or after age 60.

You are not eligible to receive long-term disability benefits if you are receiving workers' compensation benefits.

Travel Assistance Program

An added benefit, included with your employer sponsored basic life benefit, is access to The Standards Travel Assistance Program. With this additional benefit, when you travel more than 100 miles from home or internationally for up to 180 days, you have access to:

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support, and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employees home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assists with making arrangements with providers of specialized security forces

Contact travel assistance in the United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda at 800.527.0218, Everywhere else at 410.453.6330 or at assistance@uhcglobal.com. Additional information may be found at www.standard.com/travel. The group number associated with the program is 9061.

Employee Assistance Program

An added benefit, included with your employer-sponsored disability program, is access to The Standard's Employee Assistance Program (EAP). This program provides you with confidential access to experienced master's-degreed clinicians who will provide you with unlimited telephonic consultations or direct to you the resources you need, with 3 face-to-face sessions per issue. EAP services can help with child care and elder care; substance abuse; life improvement; difficulties in relationships; stress and anxiety with work or family; depression; financial and legal concerns; grief and loss; online preparation, etc.

You may access EAP services 27/7/365 at 888.293.6948 or via the web at www.workhealthlife.com. Enter standard as the login ID and eap4u as the password.

Flexible Spending Accounts

Open enrollment for Flexible Spending Accounts (FSA's) – "Flex" is in November.

For additional information please reference: http://bit.ly/1bV0CwY

Questions & Answers

Where can I locate additional plan information?
Please reference: http://bit.ly/1aJB6tx for Summary Plan Documents.

Do I need to complete an enrollment form?

- If you have employee only medical coverage and no vision coverage, you DO NOT need to do anything
- If you currently OPT-OUT and you still do not want coverage, you DO NOT need to do anything.
- If you are paying your insurance premiums (health, dental or vision) on an AFTER-TAX basis, you MUST resubmit your enrollment forms even if you are not making any changes.
- If you have NO CHANGES and you pay your insurance premiums (health, dental or vision) on a PRE-TAX basis, you DO NOT need to do anything.
- If you HAVE CHANGES, complete the required form(s) and submit to Human Resources NO LATER than May 31, 2018.

What if I waive (opt- out of) Medical coverage?
Provided you present Human Resources with proof of other health insurance coverage along with a completed Employee Waiver Form, you may be eligible to receive a $100/ month stipend.

Although waiving medical coverage, you are still eligible to enroll in the dental plan but will receive a reduction in the $100/ month stipend for waiving medical coverage. Please contact Human Resources for cost information.

When are forms due?
All forms may be returned to Human Resources anytime during open enrollment (05/01/2018 – 05/31/2018).

When are changes effective?
All benefits are effective 07/01/2018 and, unless you have a qualifying event, are effective through 06/30/2019.

Who do I contact with additional questions?
Contact Catherine Lessnau at clessnau@albion.edu with any questions.

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

Annual Compliance Notices:

Grandfathered Health Plan Notice

Albion College believes that the two Blue Cross Blue Shield of Michigan PPO plan options available under the Plan are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the grandfathered Blue Cross Blue Shield of MI PPO plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to Human Resources at (517) 629-0205 or via email at HR@albion.edu.

Important Notice about Group Health Plan Special Enrollment Rights

This notice is being provided so that you understand your right to apply for group health plan coverage outside of the open enrollment period. You should read this notice regardless of whether or not you are currently covered under the Albion College Plan.

You may have the right to enroll in the following group health plan options if certain events (listed below) occur at any time during the year: Blue Cross Blue Shield of Michigan PPO Plan 002; Blue Cross Blue Shield of Michigan PPO Plan 003.

The following are the events for which you may have a special enrollment right:

Loss of Other Group Health Plan Coverage or Health Insurance
If you decline coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **30 days** after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth or Adoption
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible. However, you must request enrollment within **30 days** after the marriage, birth, adoption or placement for adoption.

Loss of Coverage under Medicaid or State Children's Health Insurance Program
If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within **30 days** after your or your dependents' coverage under Medicaid or state children's health insurance program ends.

Eligibility for State Premium Assistance Subsidy

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to group health plan coverage under this Plan, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible. However, you must request enrollment within **30 days** after your or your dependents' determination of eligibility for such assistance. More information about these subsidies is included in "Important Notice about Free or Low-Cost Health Coverage for Children and Families under Medicaid and the Children's Health Insurance Program" on page 16 of this guide.

To request special enrollment or obtain more information, contact Albion College Human Resources at 517-629-0205 or via email at hr@albion.edu.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Albion College	4. Employer Identification Number (EIN) 38-1359081	
5. Employer address 1003 E. Cass Street	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? Human Resources Office		
11. Phone number (if different from above)	12. Email address HR@albion.edu	

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

- As your employer, we offer a health plan to:

[X] All employees. Eligible employees are:

An active executive staff, faculty or administrative employee regularly working at least 32 hours each week, OR a facilities employee subject to a collective bargaining agreement and regularly working at least 25 hours per week, OR an active secretarial or clerical employee subject to a collective bargaining agreement and regularly working at least 21 hours per week.

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[X] We do offer coverage. Eligible dependents are:

[ ] We do not offer coverage.

[X] 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? First of the month following your date of hire (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*?
☒ 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? $**0**
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? Plans will be Non-Grandfathered
☐ 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.* (Premium should reflect the discount for wellness programs. See question 15.)

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

• 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)

Note Regarding "Pre-Existing Condition Exclusions"

Effective for plan years beginning on or after January 1, 2014, a group health plan may NOT impose a pre-existing condition exclusion (PCE) with respect to any individual.

Notice of 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). However, you must request enrollment within 30 days after you or your dependents' other coverage ends or after the employer stops contributing toward the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Albion College Human Resources at hr@albion.edu.

Patient Protection Model Disclosure

Blue Cross Blue Shield of MI generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Cross Blue Shield of MI may designate one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Cross Blue Shield of MI at www.bcbsm.com.

You do not need prior authorization from Blue Cross Blue Shield of MI or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Cross Blue Shield of MI at www.bcbsm.com.

WHCRA Notice

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

All stages of reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance;

Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Albion College Human Resources at hr@albion.edu.

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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, 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 12/31/2019)

****Continuation Coverage Rights Under COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employees becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must notify the plan administrator within 60 days after determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Important Notice from Albion College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Albion College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare 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 join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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.**

2. **Albion College has determined that the prescription drug coverage offered by the Albion College BCBS health plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Albion College coverage will (or will not) be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Albion College coverage, be aware that you and your dependents will (or will not) (Medigap issuers must insert *"will not"*) be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Albion College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information [or call **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Albion College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- 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 Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	07/01/2018
Name of Entity/Sender:	Albion College
Contact--Position/Office:	Catherine Lessnau, Assistant Director of Human Resources
Address:	611 East Porter, Albion, MI 49224
Phone Number:	517/629-0205

Glossary of Terms (Please note not all terms noted below are used in this guide)

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Consumer-driven (also known as consumer-directed or consumer choice) Health Care (CDHC) – Health insurance programs and plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment – A flat fee that you pay toward the cost of covered medical services.

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA) – An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Savings Account (HSA) – An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High Deductible Health Plan (HDHP) – A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-Network – Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Member – You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-Network – Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-Pocket Expense – Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OOPM) – The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO) – A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium – The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP) – A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.