2020

# Benefits Enrollment Guide

**Lockport Township Fire Protection District**

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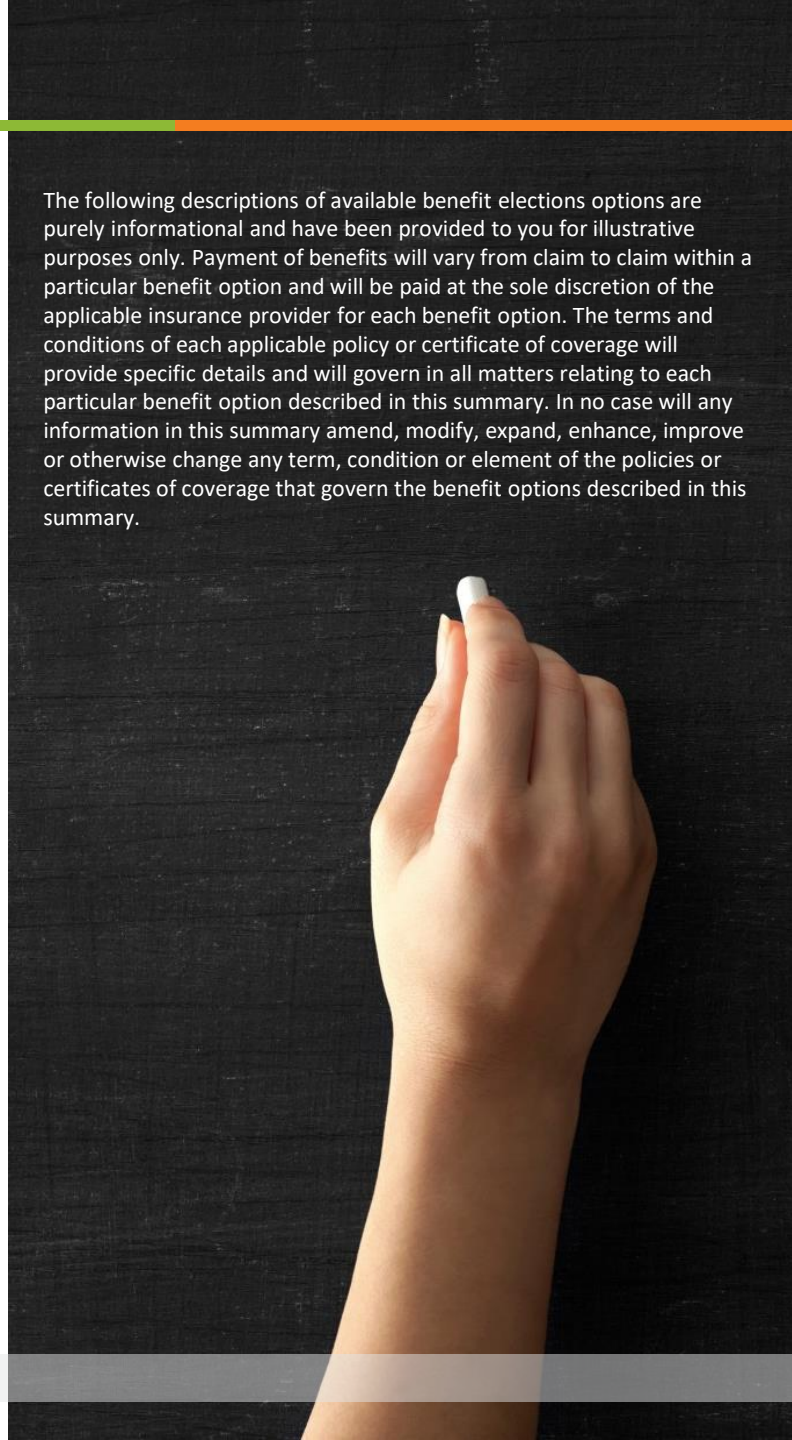
The following descriptions of available benefit elections options are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.



Presented by:
ONEDIGITAL
HEALTH AND BENEFITS

# Enrollment and Eligibility

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

## How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms or log on to your benefit administration system.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

## Whom Can You Add to Your Plan?

**Eligible:**

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

**Ineligible:**

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

## Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee and you may not be eligible to enroll.

**Examples of changes in status:**

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

*Did you know?*

**Open Enrollment is the only chance to make changes, unless you experience a “change in status.”**

# Contact Information

After you have enrolled in insurance coverage, you may receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. Once you are enrolled, we encourage you to register as a member at the insurance carrier website.

| | | |
|---|---|---|
| **MEDICAL PLANS** | | |
| ▪ Verify eligibility for a particular medical service or procedure<br>▪ Check the status of a claim<br>▪ Request an ID card<br>▪ Find a provider | **Blue Cross / Blue Shield of Illinois**<br>HMO: 800-892-2803<br>PPO/HDHP: 800-541-2767<br>**www.bcbsil.com** | HMO MIBAH202 Grp # tbd<br>PPO MIBPP002 Grp # tbd<br>HDHP MIEEE204 Grp # tbd |
| **DENTAL PLAN** | | |
| ▪ Verify coverage for a particular service<br>▪ Check the status of a claim<br>▪ Print ID card | **Guardian**<br>Customer Service: 800-541-7846<br>**www.guardiananytime.com** | Group # 573575 |
| **VISION PLAN** | | |
| ▪ Verify coverage for a particular service<br>▪ Find a provider | **VSP Vision Care (by The Standard)**<br>Customer Service Standard: 800-628-8600<br>Customer Service VSP: 800-877-7195<br>**www.standard.com**<br>**www.vsp.com** | Group # 167414 |
| **LIFE / AD&D PLANS** | | |
| ▪ How do I file a claim?<br>▪ What is covered? | **The Standard**<br>Life Plans: 800-628-8600<br>**www.standard.com** | Group # 167414 |
| **EMPLOYEE ASSISTANCE PROGRAM (EAP)** | | |
| ▪ Assistance for you or your family member is available 24 hours a day, 7 days a week | **ERS**<br>Customer Service: 800-292-2780<br>**www.ers.eap.com** | Group # TBD |

**Insurance is complicated. Digital understands. We respond. We act. We help.**

Broker Contact:

Cindy Maloberti, *Client Service Specialist*
P: 847-294-0000 x6754
E: cmaloberti@onedigital.com

Crissy Cooper, *Sr. Benefits Consultant*
P: 847-294-0000 x 6974
E: ccooper@onedigital.com

Gary Kosnoff, *Principal*
P: 847-294-0000 x 6760
E: gkosnoff@onedigital.com

Office Hours: Monday-Friday 7:30 am to 4:30 pm CST

After Hours: Monday – Friday (available until 7 pm CST)
Client Advocate Center
P: 866-736-6640 E: service@onedigital.com

# HMO Medical Plan: **BlueCross/BlueShield of IL**

| | HMO MIBAH202 | |
|---|---|---|
| | Your cost In-Network | Out-of-Network |
| Deductible | $0 | No Benefits Out-of-Network or Non-Referred Care. All HMO care must be referred via your Primary Care Physician (PCP). |
| Coinsurance | 0% | |
| Out-of-Pocket Limit (copays apply) | $1,500 Individual / $3,000 Family | |
| Preventive Care | No charge | |
| Office Visits – Primary Care / Specialist | $20 Primary Care / $40 Specialist copay per visit | |
| Virtual Visits | Not Covered | |
| Diagnostic Test / Imaging | No charge | |
| Hospital Stay | No charge | |
| Outpatient Surgery | No charge | |
| Urgent Care | $20 copay / $40 copay per visit (depending on provider type)<br>(Must be affiliated with member's chosen medical group or Referral required) | |
| Emergency Room Care | $250 copay / visit (copay waived if admitted) | |
| Prescription Drugs | | |
| Retail Pharmacy (30 day supply)<br>- Generic: Preferred<br>- Generic: Non-Preferred<br>- Brand: Preferred<br>- Brand: Non-Preferred<br>- Specialty: Preferred<br>- Specialty: Non-Preferred<br>Home Delivery (90 day supply) | <br>$0 copay<br>$10 copay<br>$50 copay<br>$100 copay<br>$150 copay<br>$250 copay<br>2x retail copay<br>** Some brands may be placed in generic tiers and some generics may be placed in brand tiers* | |
| Prescription Drug List | 2020 HMO Performance Drug List | |
| How to Find a Provider | Go to www.bcbsil.com, click on 'Find a Doctor or Hospital', 'Search as Guest', 'Search In-Network Providers' and answer the questions and select the Plan/Network from the drop-down list | |
| Plan Network | Blue Advantage HMO [ADV] | |

*The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.*

# PPO Medical Plan: **BlueCross/BlueShield of IL**

| | PPO MIBPP002 | | |
|---|---|---|---|
| | Your cost In-Network | | Your cost Out-of-Network |
| Deductible | $500 Individual<br>$1,500 Family | | $1,000 Individual<br>$3,000 Family |
| Coinsurance | 10% after deductible | | 30% after deductible |
| Out-of-Pocket Limit<br>(deductible, coinsurance, copays apply) | $1,500 Individual<br>$4,500 Family | | $4,500 Individual<br>$13,500 Family |
| Preventive Care | No Charge | | 30% (after deductible is met) |
| Office Visits – Primary Care / Specialist | $20 Primary Care / $40 Specialist copay / visit | | 30% (after deductible is met) |
| Virtual Visits | $20 copay / visit | | Not covered |
| Diagnostic Test (x-ray, blood work) | $20 PCP / $40 SPC per visit | | 30% (after deductible is met) |
| Imaging (CT/PET scans, MRIs) | 10% (after deductible is met) | | 30% (after deductible is met) |
| Hospital Stay | 10% (after deductible is met) | | $300 copay / visit plus 30% (after deductible is met) |
| Outpatient Surgery | 10% (after deductible is met) | | 30% (after deductible is met) |
| Urgent Care | 10% (after deductible is met) | | 30% (after deductible is met) |
| Emergency Room Care | $150 copay / visit (copay waived if admitted) | | |
| Prescription Drugs | *Member Pay the Difference Program | | |
| Retail Pharmacy (30 day supply)<br>- Generic: Preferred<br>- Generic: Non-Preferred<br>- Brand: Preferred<br>- Brand: Non-Preferred<br>- Specialty: Non-Preferred<br>Home Delivery (90 day supply) | Preferred Pharmacy<br>$0 copay<br>$15 copay<br>$30 copay<br>$50 copay<br>$150 copay<br>2x retail copay | Non Preferred Pharmacy<br>$0 copay<br>$15 copay<br>$30 copay<br>$50 copay<br>$150 copay | 50% additional charge after the applicable copay for Non-Preferred Pharmacy |
| | ** Some brands may be placed in generic tiers and some generics may be placed in brand tiers* | | |
| Prescription Drug List | 2020 Non-HMO Enhanced Drug List | | |
| How to Find a Provider | Go to www.bcbsil.com, click on 'Find a Doctor or Hospital', 'Search as Guest', 'Search In-Network Providers' and answer the questions and select the Plan/Network from the drop-down list | | |
| Plan Network | Participating Provider Organization [PPO] | | |

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# HDHP Medical Plan: **BlueCross/BlueShield of IL**

| | PPO / HDHP MIEEE204 [HSA Compatible Plan] | | |
|---|---|---|---|
| | Your cost In-Network | | Your cost Out-of-Network |
| Deductible | $2,800 Individual<br>$5,600 Family | | $5,600 Individual<br>$11,200 Family |
| Coinsurance | 0% after deductible | | 0% after deductible |
| Out-of-Pocket Limit<br>(deductible, coinsurance, & copays apply) | $2,800 Individual<br>$5,600 Family | | Individual: $5,600<br>Family: $11,200 |
| Preventive Care | No Charge | | 0% (after deductible is met) |
| Office Visits – Primary Care | 0% (after deductible is met) | | 0% (after deductible is met) |
| Office Visits – Specialist | 0% (after deductible is met) | | 0% (after deductible is met) |
| Virtual Visits | 0% (after deductible is met) | | Not covered |
| Diagnostic Test / Imaging | 0% (after deductible is met) | | 0% (after deductible is met) |
| Hospital Stay | 0% (after deductible is met) | | $300 plus 0% (after deductible is met) |
| Outpatient Surgery | 0% (after deductible is met) | | 0% (after deductible is met) |
| Urgent Care | 0% (after deductible is met) | | 0% (after deductible is met) |
| Emergency Room Services | 0% (after deductible Is met) | | |
| Prescription Drugs | *Member Pays the Difference Program | | |
| Retail Pharmacy (30 day supply)<br>- Preferred Generic<br>- Non-Preferred Generic<br>- Preferred Brand<br>- Non-Preferred Brand<br>- Preferred Specialty<br>- Non-Preferred Specialty | Preferred Pharmacy<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>*Some brands may be placed in generic tiers and some generics may be placed in brand tiers* | Non Preferred Pharmacy<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance<br>0% coinsurance | 50% additional charge after the Non Preferred coinsurance. Additional charge will not apply to any deductible or out of pocket amounts. |
| Prescription Drug List | 2020 Non-HMO PerformanceDrug List | | |
| How to Find a Provider | Go to www.bcbsil.com, click on 'Find a Doctor or Hospital', 'Search as a Guest', 'Search In-Network Providers' and answer the questions and select the Plan/Network from the drop-down list | | |
| Plan Network | Participating Provider Organization [PPO] | | |

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# Health Savings Account (HSA)

For employees who elect the HDHP, you have the option of opening a Health Savings Account (HSA). The HSA-eligible plan provides a way to save money that becomes available in future years for health care expenses. The HSA can be funded with pre-tax dollars by you, your employer or by anyone else to help pay for eligible medical, dental and vision expenses.

| Who is eligible for an HSA? | Why should I elect an HSA? | Maximum Contribution Allowed |
|---|---|---|
| Anyone who is:<br>• Covered by a high-deductible health plan<br>• Not covered under another medical plan that is not a high-deductible health plan<br>• Not entitle to (eligible and enrolled) Medicare benefits<br>Funding restrictions may apply for certain owners, family members of Sub-Chapter S, LLC & LLPs | • Triple Tax benefits<br>  • HSA contributions are excluded from federal income tax<br>  • Interest earnings are tax-deferred<br>  • Withdrawals for eligible expenses are exempt from federal income tax<br>• Funds roll over from year to year<br>• Account is portable – you take it with you if you leave the company<br>• Funds can be invested much like a 401(k) | **2020**<br>**Employee only coverage: $3,550**<br>**Family coverage: $7,100**<br>**If you are 55 or older, you can make a $1,000 catch-up contribution.** |

*When do I use my HSA?*

After visiting a physician, facility or pharmacy, your medical claim will be submitted to BCBSIL for payment. The claim will be processed and discounts applied. Your HSA dollars can be used to pay your out-of-pocket expenses (deductible and coinsurance) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense.

**If you are considering joining the PPO high deductible health plan and setting up an HSA**, you are strongly advised to review the following websites for some HSA educational tools.
https://hellofurther.com/ - Under 'Products,' select '**HSA**' then click on '**Visit the Learning Center**'
Calculators: https://www.firstambank.com/personalbanking/healthsavings/hsacalculators/

**Please note, the tools are through HSA administrators/custodians. While you do not have to set up your HSA with them, the educational videos & calculators provide good HSA education.*

For eligible medical expenses, refer to IRS Publication 502 - https://www.irs.gov/publications/p502/ar02.html

# Prescription Drug Information

Blue Cross and Blue Shield of Illinois (BCBSIL) wants to help you better understand your prescription drug coverage and options, including convenient services and any limitations. Here you'll find helpful information.

**CVS Exclusion – Applies to PPO and HSA plans Only**
CVS pharmacies and CVS pharmacies in a Target are not part of BCBSIL's pharmacy network as of 1/1/2017.

**Preferred Pharmacy Network – Applies to PPO plans**
Your BCBSIL prescription drug benefit plan may have a Preferred Pharmacy Network. When you go to a preferred pharmacy to fill a prescription, you'll pay less out-of-pocket. Preferred Pharmacies in your network are: Walgreens, Jewel-Osco, Walmart and Health Mart Atlas. As of January 1, 2019, Sam's Club is no longer a Preferred Pharmacy.

**Prescription Drug List**
A drug list is a list of drugs that are covered under your prescription drug benefit. How much you pay out of pocket is determined by whether your drug is on the list and at what coverage level, or tier. A generic drug is often at the lower tier. BCBS drug lists can be found by going to www.bcbsil.com, click on Member Services tab, click on Prescription Drug Lists.

**Generic Drug Information**
A generic drug is a version of a brand-name drug, and is also approved by the U.S. Food and Drug Administration (FDA). When compared to the brand drug, a generic drug is the same, is as safe, and works just as well in the body for most people. But the generic drug often costs less. There are two types of generics:
A **generic equivalent** is made with the same active ingredient(s) at the same dose as the brand drug.
A **generic alternative** is often used to treat the same condition, but the active ingredient(s) differs from the brand drug.
Your pharmacist can often substitute a generic equivalent for its brand counterpart without a new prescription from your doctor. But only you and your doctor can decide if a generic alternative is right for you. Talk to your doctor to find out if a generic drug might be an option for you.

**Specialty Pharmacy Program**
Your prescription drug benefit may include a specialty pharmacy program. Specialty medications are those used to treat serious or chronic conditions. Members are required to purchase their specialty medications through AllianceRx Walgreens Prime at the specialty copay/coinsurance. There is a 30 day supply limit.

**Dispensing Limits**
Your prescription drug coverage includes limits on certain medications. Limits may include quantity of covered medication per prescription or quantity of covered medication in a given time period.

**Prior Authorization / Step Therapy Program**
The prior authorization/step therapy program is designed to encourage safe, cost-effective medication use.
Prior Authorization - Under this program, your doctor will be required to request pre-approval through BCBSIL in order for you to get benefits for select drugs.
Step Therapy - The step therapy program requires that you have a prescription history for a "first-line" medication before your benefit plan will cover a "second-line" drug.

**Vaccine Program – Applies to PPO and HSA plans Only**
Based on your plan, vaccinations may be covered under the medical benefit or prescription drug benefit.

**No longer covered**
Certain agents or medication categories may no longer be covered under the group's pharmacy benefit. These include brand-name proton pump inhibitors (PPIs) and non-FDA approved medications. Some pharmacy benefit plans will also exclude coverage for compound drugs. Medications with an equivalent available over-the-counter (OTC) are usually not covered through BCBSIL prescription drug plans.

# Prescription Drug Information (continued)

**PPO - Mail Service Program**
AllianceRx Walgreens Prime, the mail service pharmacy for members, provides safe, fast and cost-effective pharmacy services that can save you time and money. With this program, you can obtain up to a 90-day supply of long-term (or maintenance) medications. For more information about using mail service, call the Pharmacy Program number on the back of your ID card. Based on your benefit, you may be able to fill up to a 90-day supply of prescription drugs at the Preferred pharmacies.

**HMO – 90-Day Supply Program** *(if applicable)*
With this program, you have the option of obtaining up to a 90-day supply of long-term medications through a network of contracting extended supply retail and mail service pharmacies. If you have questions about the 90-day supply program, call the Pharmacy Program number on the back of your ID card.

**Member Pay the Difference Program**
Through BCBSIL, your prescription drug benefit uses a Member Pay the Difference pharmacy benefit designed to encourage members to use medicines that have been shown to be safe and cost-effective. When you fill a prescription for a covered brand name drug where a generic equivalent is available, you may pay more. You will pay your copay/coinsurance amount plus the difference in cost between the brand drug and its generic equivalent.

*For additional information, please go to www.bcbsil.com, click on the Member Services tab.*
*If you would like to see which of these apply to your benefit plan, call the Pharmacy Program number on the back of your ID card.*

**Prime Therapeutics**
Your BCBSIL prescription drug benefits are administered by Prime Therapeutics, the pharmacy benefit manager.

Visit Prime Therapeutics at www.myprime.com to
Find medicine, along with cost-saving tips, coverage information, price estimates, drug interactions and more
Find pharmacies – get prices, directions and find a participating pharmacy near you
Your history – view and track your prescription history
Forms you need – forms for new orders, refills, home delivery information and more

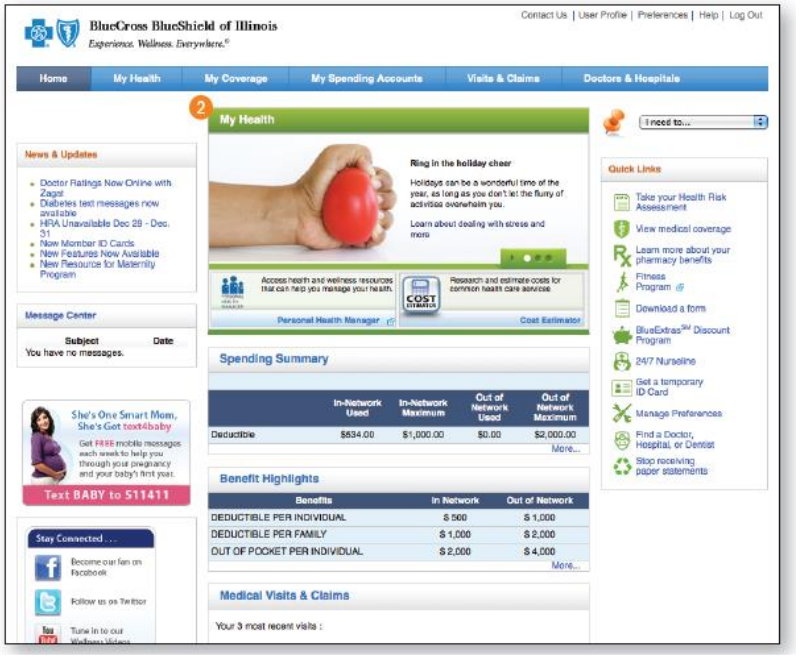
**Outpatient Infusion: Site of Care – Applies to PPO plans only** *(if applicable)*
New plan designs to incentivize members to use more cost-effective sites of care. Members will receive navigation towards a more cost effective site during Pre-Authorization. Cost shares will reflect: In network Professional copay: $50. In network Facility copay: $500. Deductible and coinsurance apply after the copays. Out of network: deductible and coinsurance.

*This is only a brief description of some of the prescription drug benefits. Not all benefits are offered by all health plans. For more complete details, including benefits, limitations and exclusions, please refer to your benefit materials.*

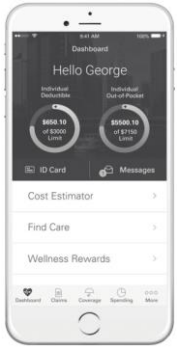
# Find what you need at Blue Access for Members (BAM)

**Your Online Resources:**

- Check the status or history of a claim
- View or print Explanation of Benefits (EOB) statements
- Locate a doctor or hospital in your plan's network
- Request a new ID card or print a temporary one
- Access health and wellness information
- Use the **Cost Estimator** tool to research, estimate and compare costs of services and treatments from doctors, hospitals and other facilities based on your plan coverage




## Go Mobile with the BCBSIL App!




Stay connected with BCBSIL and access important health benefit information wherever you are.

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View and email your member ID card
- Download and share your Explanation of Benefits

Text BCBSILAPP to 33633 to get the app

*It's easy to get started*

- Go to bcbsil.com/member
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process.

# Health and Wellness Resources

**Virtual Visits** (Available to Non-HMO Members) 888-676-4204

Getting sick is never convenient and finding time to get to the doctor can be hard. MDLIVE's telehealth program provides you and your covered dependents access to care for non-emergency medical and behavioral health needs. Whether you're at home or traveling, access to an independently contracted board-certified MDLIVE doctor is available 24 hours a day/seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.

MDLIVE doctors or therapists can help treat the following conditions and more:
**Generals Health:** Allergies, asthma, nausea, sinus infections
**Pediatric Care:** Cold, flu, ear problems, pink eye
**Behavioral Health:** Anxiety/depression, child behavior/learning issues, marriage problems

Prescriptions sent electronically to a pharmacy of your choice, when appropriate.

Connect with MDLIVE via their website www.MDLIVE.com/bcbsil, mobile app 'MDLIVE', or telephone 888-676-4204.

**24/7 Nurseline** (Available to Non-HMO Members) 800-299-0274

Health happens – that is why there are registered nurses waiting to talk to you whenever you call the 24/7 Nurseline. The nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with you doctor. Plus, when you call, you also have the option to access an audio library of more than 1,000 health topics – from allergies to surgeries.

The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

Note: For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

**Special Beginnings** (Available to Non-HMO Members) 888-421-7781

The Special Beginnings maternity program supports you from early pregnancy until six weeks after delivery. An experienced BCBSIL staff member will contact you and: ask questions to determine what support you will need; send you information, including a book about having a healthy pregnancy and baby; answer any questions you have and help you plan your care with your doctor; assist you with managing high-risk conditions such as gestational diabetes and preeclampsia. Visit the Special Beginnings website to view a video library and week-by-week pregnancy information. It's free, easy and confidential.

To access the site log into Blue Access for Members by visiting bcbsil.com

# Health and Wellness Resources (continued)

**Well onTarget** *(Mobile app - **AlwaysOn**)*

Wellness involves making healthy choices that enrich the mind, body and spirit. Well onTarget is a program designed to give employees the tools and support they need, while rewarding them for making healthy choices. You will have access to a convenient, secure website which includes a health assessment, interactive tools and information and a points reward program.

**Well onTarget Member Wellness Portal**

At the heart of Well onTarget is the member portal. It links you to a suite of innovative programs, including:

**Health Assessment (HA)**

Take the HA to get a personalized wellness report and tips for living your healthiest life. Your answers are confidential and the assessment will be used to tailor the Well onTarget portal with programs that can help you reach your goals and understand your body.

**Health and Wellness Content**

Online health encyclopedia that educates and empowers you through evidence-based, consumer-friendly content.

**Tools and Trackers**

Interactive tools help keep you on course while making wellness fun. Use food and workout diaries, health calculators and medical and lifestyle trackers.

**Self-directed Courses**

Online courses let you work at your own pace to reach your health goals. Learn more about managing stress, quitting tobacco, weight management, improving nutrition and getting active. Track your progress as you make your way through each lesson. Reach your milestones and earn Blue Points.

**Blue Points**

Take advantage of the resources available to you online and earn Blue Points! You can earn points for completing a health assessment, connecting a fitness device, tracking activity and more. You can use your points to redeem through the shopping mall.

**The Fitness Program** 888-762-2583

This program gives you unlimited access to a nationwide network of gyms. Available to members and their covered dependents (age 18 and older).

- No long-term contract: Membership is month to month. Monthly fees are $25 / month per member, with a one-time enrollment fee of $25 per member.
- Unlimited access to a nationwide network of more than 10,000 fitness locations.
- Complementary and Alternative Medicine (CAM) discounts: Save money through a nationwide network of 40,000 health and well-being providers, such as acupuncturists, massage therapists and personal trainers.
- Blue Points: Get 2500 points for joining the Fitness Program. Earn additional points for weekly visits.
- Web Resources: Go online to find fitness locations and track your visits.
- Convenient Payment: Monthly fees are paid via automatic credit card or bank account withdrawals.

Go to bcbsil.com and log in to Blue Access for Members for more information.

*Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.*

# Health and Wellness Resources – Blue 365 Member Discount Program

**Blue365 Member Discount Program**

Blue365 is just one more advantage of being a Blue Cross and Blue Shield of Illinois (BCBSIL) member. With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations.

Once you sign up for Blue365 at **blue365deals.com/BCBSIL**, weekly "Featured Deals" will be emailed to you. These deals offer special savings for a short period of time. Below are some of the ongoing deals offered to Blue365 members.

## FITNESS

- Save on Gym Memberships: **Gym Network 360**, **Fitness Your Way**
- Save on Products: LED Safety, Heart Rate Monitors, **Bellabeat**, **BodiMetrics**, **Fitbit**, **Skechers and Reebok**

## PERSONAL CARE

- Save on Vision: **EyeMed** (Exam & Glasses), **Glasses.com**, **ContactsDirect**, **Davis Vision**, **Qualsight Lasik**, **LasikPlus**
- Save on Hearing: **TruHearing, Beltone, American Hearing Benefits**
- Save on Products: Medical Bracelets, Dental Solutions, **Dentisse**

## HEALTHY EATING

- **Sun Basket** – Savings on Meal Delivery Kit Orders
- **Hungry Harvest** – Savings on Fruit and Vegetable Delivery
- **InsideTracker** – Savings on Personalized Nutrition Plan
- **Holly Clegg** – Savings on Trim & Terrific Cookbooks
- **Nutrisystem** – Discount on Nutrition Products and Services
- **Jenny Craig** – Free 3 Month Membership and Food Discounts

## WELLNESS

- **Molecular Fitness** – Savings on Genetic Composition
- **Invite Health** – Savings on non-GMO vitamins & supplements

## FINANCIAL HEALTH

- **Petplan** – Discount on Pet Insurance
- **Sprint** – Savings on select monthly plans
- **Quicken Loans** – Mortgage Savings

## LIFESTYLE

- **Last Minute Travel Club** – Free Membership to Access Club Discounts
- **Fairmont Hotels & Resorts** – Discount on Room Rate

Deals are current as of 2/2019

*BCBSIL does not guarantee or make any claims or recommendations regarding the services or products offered under Blue365. You may want to consult with your physician prior to use of these services and products. Services and products are subject to availability by location. BCBSIL reserves the right to discontinue or change this discount program at any time without notice.*

# The Blue Card Program

**Traveling across the country or around the world?**
The BlueCard program helps Blue Cross and Blue Shield of Illinois (BCBSIL) members:

- Get needed health care when you travel or live outside your Blue Plan service area
- Get the same benefits as your BCBSIL plan when you travel or are away from home for an extended amount of time
- Find a doctor or hospital throughout the United States – More than 90% of all hospitals and doctors in the U.S. contract with Blue Cross and Blue Shield
- Find a doctor or hospital outside the U.S. in more than 200 countries around the world through Blue Cross and Blue Shield Global Core

Here are some key points to remember about using the BlueCard Program.

- Always carry your most current BCBSIL ID card; it contains important information your health care providers need.
- When you're outside of your local BCBSIL service area and need health care, refer to your ID card and call BlueCard Access at 800-810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder at bcbs.com for information on the nearest PPO doctors and hospitals.
- In an emergency, go to the nearest hospital.

BlueCard coverage varies for each BCBS Plan. It depends on if you choose a provider who contracts with BCBS. Be sure to call Customer Service at the number on the back of your member ID card before you travel. Log in to Blue Access for Members to find more information about Blue Card.

Note: HMO plan members can use the BlueCard Program only for emergency or urgent care when traveling or away from home for less than 90 days.

**The Away from Home Care® Program**
Access for Extended Stays (Temporarily Residing Away From Home)
BCBSIL members who have HMO plans may become guests of an affiliated HMO when they are away from home for at least 90 days. The Away From Home Care Program is ideal for members who:

- Have a child attending school out of state
- Have family members who live in different service areas
- Have a long-term work assignment in another state

This program allows ongoing access to contracting hospitals and doctors. If you are already a BCBSIL member, log in to Blue Access for Members to get more information about Away From Home Care. Call the customer service number on the back of your member ID card to find out where the program is available.

*This is only a brief description of some of the plan benefits. Not all benefits are offered by all Plans mentioned above. For more complete details, including benefits, limitations and exclusions, please refer to your certificate of coverage.*

# Dental Plan: **Guardian**

| | PPO Dental | |
|---|---|---|
| | Your cost In-Network | Your cost Out-of-Network |
| Annual Deductible | $50 Individual<br>$150 Family | $50 Individual<br>$150 Family |
| Deductible is waived for Preventive? | Yes | Yes |
| Preventive Services<br>(Exam, Cleanings, X-Rays, Fluoride, Sealants) | 0% | 0% |
| Basic Services<br>(Fillings, Extractions, Periodontics, Endodontics) | 20% (after deductible is met) | 20% (after deductible is met) |
| Major Services<br>(Bridges, Dentures, Crowns, Implants) | 20% (after deductible is met) | 20% (after deductible is met) |
| Annual Benefit Maximum | $2,000 / person | |
| Maximum Rollover | Guardian will roll over a portion of your unused annual maximum.<br>You must have a paid claim and not exceed the paid claims threshold of $800 during the benefit year.<br>Rollover Amount = $400; $600 if only in-network providers were used.<br>Rollover account limit = $1,500 | |
| Annual Orthodontia (Adults & Children) | 50% up to $2,000 | |
| How to Find a Provider | Go to www.guardiananytime.com, click on 'Find a Provider', 'Search Providers', 'Find a Dentist' tab, select plan type & network | |
| Plan Type<br>Dental Network | PPO<br>DentalGuard Preferred | |

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

# Dental Maximum Rollover

## Dental Maximum Rollover®

### Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

*Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.*

| Plan Annual Maximum* | Threshold | Maximum Rollover Amount | In-Network Only Rollover Amount | Maximum Rollover Account Limit |
|---|---|---|---|---|
| $2000 | $800 | $400 | $600 | $1500 |
| Maximum claims reimbursement | Claims amount that determines rollover eligibility | Additional dollars added to Plan Annual Maximum for future years | Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year | Plan Annual Maximum plus Maximum Rollover cannot exceed $3,500 in total |

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

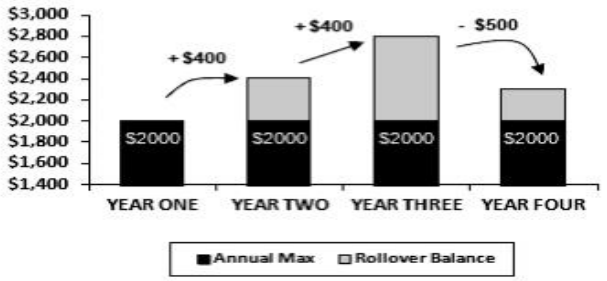
### Here's how the benefits work:

**YEAR ONE**: Jane starts with a $2000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $800 Threshold, she receives a $400 rollover that will be applied to Year Two.

**YEAR TWO**: Jane now has an increased Plan Annual Maximum of $2,400. This year, she submits $50 in claims and receives an additional $400 rollover added to her Plan Annual Maximum.

**YEAR THREE**: Jane now has an increased Plan Annual Maximum of $2,800. This year, she submits $2,500 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

**YEAR FOUR**: Jane's Plan Annual Maximum is $2,300 ($2,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).




For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

# College Tuition Benefit Rewards

**Employees now have an added incentive to participate in Guardian's Dental Plan**

They earn Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar colleges, over 340 private and universities across the nation.

**How does it work?**

- One Tuition Reward point = $1 tuition reduction
- You will receive rewards each year you have **Guardian Dental Plan benefits**
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren
- To use Tuition Rewards, a child must be registered by August 24th of the year they enter 11th grade
- The maximum rewards you can use, per registered student, cannot exceed one year's tuition at a participating school

| Policy Year | Subscriber Reward* | Subscriber's Reward Balance (balance does not accrue interest) |
|---|---|---|
| Initial Registration, Subscriber & Student Rewards | | 2,500 (2,000 + 500) |
| 2 | 2,000 | 4,500 |
| 3 | 2,000 | 6,500 |
| 4 | 4,500 (Bonus Year) | 11,000 |
| 5 | 2,000 | 13,000 |
| 6 | 2,000 | 15,000 |
| 7 | 2,000 | 17,000 |

This example shows how the program would help a 12 year old in the family of a Guardian dental subscriber. If the registered student attends a participating SAGE Scholar College, the tuition will be reduced by $17,000 spread evenly over four years.

To learn more about the program and how to get started, go to: www.Guardian.CollegeTuitionBenefit.com to set up your account.
If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly at 215-839-0119.

Register @
www.Guardian.CollegeTuitionBenefit.com

**User ID:** Type in your Guardian Dental Plan Number. (Your 'Plan Number' can be found on your Dental ID Card)

**Password:** Guardian

Guardian Dental Plan #: 573575

# Vision Plan: **The Standard through VSP**

| | VSP Choice – Balanced Care Vision 1 | |
|---|---|---|
| Deductible | $10 Exam<br>$10 Eye Glass Lenses or Frames* (*Deductible applies to a completed pair of glasses or to frames, whichever is selected) | $10 Exam<br>$10 Eye Glass Lenses or Frames |
| Maximum (per benefit period) | None | None |
| | Your cost In-Network | Your cost Out-of-Network *(after deductible if applicable)* |
| Eye Exams | $ 0 after deductible | Up to $45 |
| Single Vision Lenses<br>Lined Bifocal Lenses<br>Lined Trifocal Lenses<br>Lenticular Lenses | $0 after deductible | Up to $30<br>Up to $50<br>Up to $65<br>Up to $100 |
| Frame Allowance | Up to $150** (**Costco allowance is wholesale equivalent) | Up to $75 |
| Contact Lenses *(Evaluation & Fitting)*<br>Contact Lenses *(Elective)*<br>Contact Lenses *(Medically Necessary)* | Participant cost up to $60<br>Up to $150<br>$0 copay | No benefit<br>Up to $120<br>Up to $210 |
| Laser VisionCare | Up to 15% off the usual charge or 5% off promotional price | No discounts |
| Additional Discounts | ▪ 20% off additional complete pairs of prescription glasses and/or sunglasses (to be used after initial plan benefit is used).<br>▪ Frame discount, VSP offers 20% off any amount above the retail allowance (varies by location). | |
| Service Frequencies<br>Exams<br>Lenses *(*for glasses or contact lenses)*<br>Frames | <br>Every 12 months<br>Every 12 months<br>Every 24 months | |
| How to Find a Provider | Go to **www.vsp.com**, click on 'Find a Doctor', then choose to search by location, office or doctor and make your selection'<br>Go to www.standard.com click on 'Find an Eye Doctor, then select VSP and you will be redirected to the VSP site. | |
| Vision Network | VSP Choice Network + Affiliates (Costco & Visionworks) | |

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

* Benefit includes coverage for glasses or contact lenses, not both.

# Life and AD&D Plans: **The Standard**

## Basic Life and AD&D:

| | Benefit |
|---|---|
| Benefit Amount | $50,000 |
| Reduction Schedule | Basic Life and AD&D insurance coverage amount reduces to 60% at age 75, 35% at age 80, 28% at age 85, 20% at age 90, 8% at age 95 and 5% at age 100 |
| Additional Benefits | **Portability**<br>Allows you to take your coverage with you if you terminate employment<br>**Conversion**<br>Allows you to continue your coverage after your group plan has terminated<br>**Accelerated Life Benefit**<br>A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan<br>**Waiver of Premium**<br>Premium will not need to be paid if you are totally disabled (eligible to age 60 / waived to age 65) |
| Beneficiaries | Employees must have an up-to-date beneficiary designation on file. |
| Premium Paid By | Employer |

## Voluntary Life:

| | Employee Life Benefits | Spouse Life Benefits | Child Life Benefits |
|---|---|---|---|
| Benefit Amount | You may choose to purchase benefits in increments of $10,000 | You may choose to purchase benefits in increments of $5,000 | (age 14 days and older) You may choose to purchase benefits in increments of $2,000 |
| Minimum | $10,000 | $5,000 | $2,000 |
| Maximum | $500,000 (not to exceed 8x's your annual earnings - combined) | $250,000<br>Cannot exceed 100% of employee benefit | $10,000 |
| Guarantee Issue | $150,000 | $40,000 | n/a |
| | For benefit amounts above the guarantee issue, proof of good health is required | | |
| Reduction Schedule | Coverage amount reduces to 60% at age 75, 35% at age 80, 28% at age 85, 20% at age 90, 8% at age 95 and 5% at age 100 | | n/a |
| Additional Benefits | Portability<br>Conversion<br>Accelerated Life<br>Waiver of Premiums | | |
| Beneficiaries | Employees must have an up-to-date beneficiary designation on file. | | |
| Premium Paid By | Employee | | |

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

# Employee Assistance Program (EAP)

Employee Assistance Program is offered to all employees and immediate family members through Employee Resource Systems (ERS)

Licensed professionals provide confidential support and guidance related to:

- Family, relationship and parenting issues
- Basic child and elder care needs
- Emotional and stress-related issues
- Conflicts at work or home
- Alcohol and drug dependencies
- Personal development and general wellness issues

In addition to phone-based help, a lot of information can be found online, such as self-assessment tools, interactive databases, budgeting, health and wellness calculators, webinars and podcasts.

ERS
Employee Resource Systems, Inc.

WEBSITE: **www.ers-eap.com**

TOLL-FREE: **800-292-2780**

**WHATEVER YOU NEED,**
**WE ARE HERE TO HELP.**

***Just call or log on to get started.***

# Required Notices

## Newborn and Mothers' Health Protection Act

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

## Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been preformed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy, including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

# REQUIRED CHIP NOTICE

### 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, 2020. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br>Phone: 1-800-541-5555 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |



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# REQUIRED CHIP NOTICE (CONT)

| IOWA – Medicaid and CHIP (Hawki) | MONTANA – Medicaid |
|---|---|
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563 | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://www.kdheks.gov/hcf/default.htm<br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Medicaid Website:<br>http://www.state.nj.us/humanservices/<br>dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: http://www.mass.gov/eohhs/gov/departments/masshealth/<br>Phone: 1-800-862-4840 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]<br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |



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# REQUIRED CHIP NOTICE (CONT)

| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/hipp/<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |

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

**To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:**

## Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)



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# HIPAA Notice


**HIPAA Privacy Notices**

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

**More information can be found at**: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

**Link to model notice:**
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/nppbooklet_health_plan.pdf

**Link to OneDigital's privacy policy:** https://www.onedigital.com/privacy-policy/

**Model Special Enrollment Notice**

The following is language that group health plans may use as a guide when crafting the special enrollment notice: 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 the appropriate time period that applies under the plan 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 the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

**Link to model notice**: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

For additional information on your employer's privacy policy, please contact your HR department.

# Required Notice: Exchange/ Marketplace Availability Notice

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

## PART A: General Information

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

### What is the Health Insurance Marketplace?

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

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

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

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

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

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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.

# Required Notice: COBRA

**Notice of COBRA Continuation Coverage Rights**

***Introduction***

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

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

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

***What is COBRA continuation coverage?***

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); 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 of the following qualifying events:

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

***When is COBRA continuation coverage available?***

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

# Required Notice: COBRA

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

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.**

***How is COBRA continuation coverage provided?***

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

***Disability extension of 18-month period of COBRA continuation coverage***

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

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

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

**If you have questions**

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

**Keep your Plan informed of address changes**

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

**Plan contact information**

- Human Resources

OMB Control Number 1210-0123 (expires 1/31/2023)

# Required Notices

### Illinois Notice of Health Plan Coverage for Eligible Dependents Under the Age of 26

As part of the federal Patient Protection and Affordable Care Act (more commonly known as Health Care Reform), dependents under the age of 26 — regardless of marital status — may be eligible for coverage under your employer sponsored health plan (medical, vision and/or dental benefits), if dependent coverage is offered.

In addition, under Illinois law, any unmarried dependent child under 30 years of age is eligible for dependent coverage if the dependent meets all three (3) of the following conditions:

i. is an Illinois resident,
ii. served as an active or reserve member of any U.S. Armed Forces and
iii. received release or discharge other than dishonorable discharge

Enrollees must submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service. Please note your employer may require you to pay for all or part of the cost of your dependent's health care coverage.

For more information about plan eligibility, contact Human Resources.

### Medicare Part D Notice

Each year, employers with health plans that provide prescription drug coverage to Medicare-eligible individuals must disclose whether that coverage is creditable or non-creditable. The notice will be provided to Medicare Part D eligible individuals annually before October 15 of each year.

A group health plan's prescription drug coverage is considered creditable if it is at least as generous as Medicare Part D prescription drug coverage. Plan sponsors must tell Part D eligible individuals whether their prescription drug coverage is creditable so that the Medicare-eligible individuals can compare their existing coverage with the coverage provided under a Part D plan. Part D eligible individuals who are not covered under creditable prescription drug coverage may be subject to a permanent late enrollment penalty in the form of higher premiums in the event that they choose to enroll in Part D coverage at any time after the end of their Initial Enrollment Period.

### Patient Protection Disclosure

BlueCross BlueShield of Illinois generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSIL at 800.892.2803.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BlueCross BlueShield of Illinois 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, and is in the same medical group, 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 BCBSIL at 800.892.2803.

# Confidentiality Notice

OneDigital Health and Benefits, a division of Digital Insurance, LLC does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

# 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).

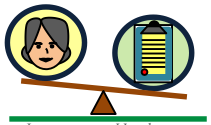
## Balance Billing

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




(See page 6 for a detailed example.)

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

## Complications of Pregnancy

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

## Copayment

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

## Cost Sharing

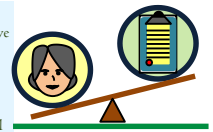
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your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




(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

## Diagnostic Test

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

## Durable Medical Equipment (DME)

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

## Emergency Medical Condition

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

## Emergency Medical Transportation

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

## Emergency Room Care / Emergency Services

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

## Excluded Services

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

## Formulary

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

## Grievance

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

## Habilitation Services

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

## Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

## Home Health Care

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

## Hospice Services

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

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

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

### Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

### In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare 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
Health coverage that will meet the individual responsibility requirement. 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.

### 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.

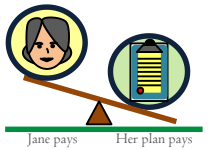
### Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

### 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.

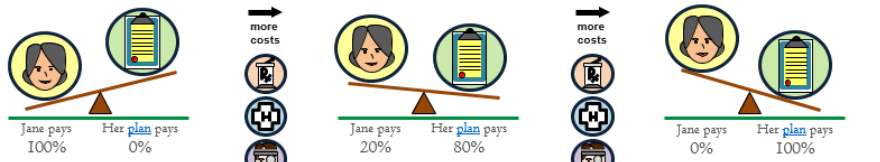


## How You and Your Insurer Share Costs - Example

**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 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

# Ways to Stretch Your Health Care Dollars

**Understand how your health plan works**
**This is the first and probably most important step. You need to know what is and what is not covered, what procedures you need to follow to ensure your claims are paid, and which providers and facilities to use to get the most cost-effective care. Know the deductibles, copayments and other out-of-pocket costs you are responsible for paying before you use medical products or services or get a prescription filled.**

**Use in-network providers**
Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider you will likely pay a higher deductible and coinsurance, plus the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.

**Shop around.**
**The cost of procedures, doctors, services and hospital visits can vary widely. You might save money by having surgery performed at an ambulatory surgical center (a clinic that is not associated with a hospital.) These sites usually charge less than hospitals or their outpatient surgical centers. Freestanding diagnostic centers are also available and tend to charge less for certain tests like MRIs, CAT scans, X-rays and bone density scans. But before you go, make sure the facility is in your plan's network and that your plan's benefits cover the service. As always, talk to your doctor to be sure this course of action is appropriate for you. Call providers to compare prices.**

**Only go to the hospital emergency room for true emergencies.**
If you need medical care when your regular doctor is not available, think about going to an urgent care center rather than a hospital emergency room. Avoiding the ER will probably save you money for two reasons: 1) the copay is usually lower for a doctor visit or an urgent care visit, and 2) your insurer might make you pay for the full cost of care if you use an emergency room for a non-emergency. Call your plan's health hotline, if available, to get advice on how, when and where to seek care in a non-emergency situation.

**Use any additional programs or discounts provided by your health plan.**
**Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition, and can possibly save you money in the long run. In addition, many offer complementary programs that are designed to prevent illness and lower health costs over the long run. These programs may include smoking cessation and weight loss programs, or discounts on fitness clubs or other items that help you live a healthy lifestyle.**

**Use a mail order pharmacy if one is available**
If you take a medication regularly, you may save money by getting a 90-day supply of your medicine through a mail order pharmacy, depending on your plan. You may save money, and the convenient delivery saves you time and effort.

**Use generic drugs whenever possible, even for over-the-counter medications.**
**The most expensive drug doesn't mean it's the best. Before your physician writes you a prescription, ask about generic equivalents, lower-cost brand name drugs to treat the same condition and even over-the-counter options.**

**Carefully check all medical bills.**
Insurance companies and hospitals are not exempt from making billing errors. Insurers often miscalculate the family deductible, so keep a careful tally of individual as well as total family payments to be sure you don't overpay. If you have a hospital stay, try to keep a log of all the services, medications and supplies you are given, so when you get a bill you can be sure you were not charged for procedures you didn't have or items you didn't use. Ask for an itemized bill. Read your EOB, if you don't understand an item on the EOB or you aren't sure you received the services listed, call the insurance company or the provider. Make sure the EOB and provider bill match.

**Live a healthy lifestyle.**
**Healthy habits like exercising regularly, eating well and not smoking can increase your stamina, improve your mood and lower your risk for certain diseases. Plus, your routine physical, preventive health screenings and vaccinations are usually covered at lower cost to you. If a screening does reveal a health issue, you are more likely to be able to treat it early, when it is easier and less expensive to treat.**

**Helpful websites**

www.healthcarebluebook.com
www.newchoicehealth.com
fairhealthconsumer.org
www.goodrx.com

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