IMPORTANT NOTICES REGARDING YOUR HEALTH INSURANCE RIGHTS

**Women’s Health and Cancer Rights Act of 1998 (WHCRA)**

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

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient

**Special Enrollment**

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

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 you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you decline enrollment for yourself or for your dependents (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

If you have any questions, please contact:
Shawnee State University
Human Resources Department
940 Second Street, Portsmouth, OH 45662-4344
(740) 351-3484

2020 Compliance Packet
Michelle’s Law (2010)

Michelle's Law prohibits the termination of health coverage if the child takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

- Be medically necessary (and certified by a physician as medically necessary)
- Commence while the child is suffering from a serious illness or injury
- Cause the child to lose student status for the purposes of coverage under the plan (either from an absence from school or reducing his/her course load to part time)

To take advantage of the extension, the child must be enrolled in the group health plan by being a student at a post-secondary educational institution immediately before the first day of the leave.

Coverage must extend for one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan). The student on leave is entitled to the same benefits as if they had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

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?

2020 Compliance Packet
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); or
- 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:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- 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: Ameriflex, COBRA Administrator (888) 868-3539.

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 the contact or contacts identified below. 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:

Ameriflex, COBRA Administrator  
(888) 868-3539

Shawnee State University Human Resources Department  
940 Second Street  
Portsmouth, OH 45662-4344  
(740) 351-3484

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review this Notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Shawnee State University plan, including each of its component health plans, (collectively the “Plan”) to provide you with this notice (“Notice”) that explains our privacy practices and outlines your rights under the Plan. This Notice does not change, diminish or limit your coverage in any way.

The terms of this Notice apply to the Plan. The information provided in this Notice applies to all persons, including all of your covered dependents.

Our Privacy Pledge

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. Additionally, we are required by law to maintain the privacy of our members’ protected health information (PHI) and provide you with certain rights with respect to your PHI.

Generally, PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, health care clearinghouse, health plan, or your employer on behalf of a health plan, that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you. This Notice applies to all of the PHI we receive about you and your applicable dependents, whether made by hospital personnel, your personal doctor, other practitioners involved in your care, our third-party claims administrator, stop-loss carrier or network providers. When contracted claims administrators and other third parties’ services involve the use of your PHI, they will be required to perform their duties in a manner consistent with this Notice. Your personal doctor may have different policies or notices regarding his/her use and disclosure of your medical information created in his/her office or clinic.

We share PHI only as necessary to carry out treatment, payment and healthcare operations for the products and services you request and as permitted by law. We will not use or disclose your PHI for employment related actions and decisions or in connection with any non-health benefits or another employee benefit plan we sponsor. We will ensure your PHI received by our Human Resources Department is not disclosed to other employees of the company in violation of this Notice. We will destroy your PHI or continue to maintain privacy of it when the law requires its retention.

We reserve the right to change the terms of this Notice (even retroactively) and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If our privacy practices change, we will send you a revised Notice if you are still a member of the Plan. Additionally, you may request a copy of this notice at any time by mailing a request to the Privacy Officer at the address at the end of this Notice.

2020 Compliance Packet
Uses and Disclosures of Your Personal Health Information

We (independently or via a third party) will not use or disclose your PHI except in the following circumstances:

Your Authorization: We may use or disclose your PHI if you have signed a form authorizing the use or disclosure and then only in accordance with such authorization. You have the right to revoke the authorization in writing at any time. Your revocation will not affect any use or disclosure made pursuant to your authorization while it was in effect.

Personal Representatives: We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (e.g., power of attorney or a court order of appointment of the person as your guardian).

Spouses and Dependents: With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee’s spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested restrictions or confidential communications (see below), and if we have agreed to the request, we will send mail as provided in the request.

Disclosures for Treatment: We may make disclosures of your PHI as necessary for your treatment. For example, a doctor involved in your care may request your PHI that we hold to supplement his/her own records.

Uses and Disclosures for Payment: We may use and disclose your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. The Plan will mail Explanation of Benefits forms and other information to you at the address on record.

Uses and Disclosures for Health Care Operations: We may use and disclose your PHI, as necessary and as permitted by law for our health care operations which may include utilization review and management, underwriting, enrollment, auditing and other functions related to your Plan. For example, we may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of the claims processing functions. However, we will not use your genetic information for underwriting purposes.

Disclosures to Family and Friends Involved in Your Care: We may disclose to designated family, friends, or others your PHI directly relevant to such person's involvement with your care or payment for your care. For example, if a family member or a caregiver calls the Plan with prior knowledge of a claim, the Plan may confirm whether or not the claim has been received and paid. You may instruct us, in writing, to stop or limit this kind of disclosure.

Outside Business Associates: Certain aspects of our services are performed through contracts with outside persons or organizations, such as auditing and legal services. At times it may be necessary for us to provide portions of your PHI to one or more of these outside persons or organizations who assist us with health care operations. In all cases, we require these business associates to safeguard the privacy of your information.

Other Health-Related Products or Services: We may use your PHI to determine whether you might be interested in, or benefit from, treatment alternatives or other health-related programs, products, or services which may be available to you under your plan. For example, we may use or disclose PHI to send you treatment reminders for services such as mammograms or prostate cancer screenings. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

2020 Compliance Packet
Other Uses and Disclosures: We are permitted by law to make certain uses and disclosures of your PHI without your authorization.

We may release your PHI for any of the following purposes:

- **Required by Law:** We will disclose your PHI when required to do so by federal, state or local law.

- **Plan Sponsor:** For purposes of maintaining the Plan, we may disclose your PHI to certain employees of the company. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures.

- **Health Oversight Activities:** We may disclose your PHI to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activities.

- **Legal Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances.

- **Law Enforcement:** We may disclose your PHI to law enforcement officials under limited circumstances. For example, in response to a warrant or subpoena; for the purpose of identifying or locating a suspect, witness, or missing person; or to provide information concerning victims of crimes.

- **For Public Health Activities:** We may disclose your PHI to a government agency that oversees the health care system or government programs for activities such as, but not limited to, preventing or controlling disease or activities related to the quality, safety or effectiveness of an FDA-regulated product or activity.

- **Workers’ Compensation:** We may disclose your PHI when authorized by and to the extent necessary to comply with workers’ compensation laws and similar programs.

- **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose your PHI to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, domestic violence or other crimes.

- **Coroners, Medical Examiners, Funeral Directors, and Organ Donation:** In certain instances, we may disclose your PHI to coroners, medical examiners or funeral directors and in connection with organ donation or transplantation.

- **Research:** We may disclose your PHI to researchers, if certain established steps are taken to protect your privacy.

- **Threat to Health or Safety:** We may disclose your PHI to the extent necessary to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of others.

- **For Specialized Government Functions:** We may disclose your PHI in certain circumstances or situations to a correctional institution if you are an inmate in a correctional facility, to an authorized federal official when it is required for lawful intelligence or other national security activities or to an authorized authority of the Armed Forces.
Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, we will make reasonable efforts not to use, disclose or request more than the minimum amount of information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment
- uses or disclosures made to the individual
- disclosures made to the Secretary of the US Department of Health & Human Services
- uses or disclosures that are required by law
- uses or disclosures that are required for the Plan’s compliance with the HIPAA Privacy Standards
- uses or disclosures made pursuant to an authorization

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual, and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, we may use or disclose "summary health information" for obtaining premium bids or modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom we have provided health benefits under the Plan, and from which identifying information has been deleted in accordance with the HIPAA Privacy Standards.

Your Rights

Access to Your PHI: You have the right to copy and inspect the PHI we retain on your behalf. All requests for access must be in writing and be signed by you or your representative. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced, we will work with you to come to an agreement on form and format and if one can’t be reached, we will provide a paper copy. We reserve the right to charge you a reasonable copying fee if you request a paper copy of the information. We also reserve the right to charge for postage if you request a mailed copy.

Amendments to Your PHI: You have the right to request, in writing, PHI we maintain about you be amended. We are not obligated to make all requested amendments, but we will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment request. If an amendment you request is made by us, we may also notify others who work with us. You may request an amendment by sending a written request to the address listed at the end of this notice.

Confidential communications: You have the right to request confidential communications. If you believe that normal communications would put you in danger (as in situations of domestic violence), you may request that the Plan send communications with PHI (e.g., an Explanation of Benefits) to you by alternative means or to an alternative location. Your request must be in writing. Such requests, if reasonable, will be accommodated when you state in the request that you believe normal communications would endanger you.

2020 Compliance Packet
Restrictions on Uses and Disclosures of Your PHI: You may request, in writing, we restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your requested restriction, but we will attempt to accommodate reasonable requests when appropriate, and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate any agreed-to restriction by sending a written request to the address listed at the end of this notice.

Accounting for Disclosures of Your PHI: You have the right to receive an accounting of certain disclosures of your PHI. Requests must be made in writing, signed by you or your representative, and sent to the address listed at the end of this notice. The first accounting of a 12-month period is free; we reserve the right to charge a fee for each subsequent accounting you request within the same 12-month period.

Breach Notification: You have the right to be notified in the event that we or a Business Associate discover a breach of your unsecured PHI.

Copy of this Notice: You have the right to a paper copy of this Notice upon request. Your request must be in writing and sent to the Privacy Officer. A copy of the current notice will be sent to you.

Complaints

If you believe your rights have been violated, you can file a complaint, in writing, to the address listed at the end of this Notice. The Privacy Officer will investigate and address any issues of noncompliance with this Notice. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights, by writing to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

For Further Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual:

Shawnee State University
Human Resources Department
940 Second Street, Portsmouth, OH 45662-4344
(740) 351-3484

This Notice attempts to summarize the HIPAA Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.
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](http://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](tel:1-877-KIDS NOW) or [www.insurekidsnow.gov](http://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](http://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 –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
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<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
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<tr>
<td>Phone: 1-855-692-5447</td>
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<tr>
<td>Health First Colorado Website: <a href="http://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
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<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
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<tr>
<td>Phone: 1-866-251-4861</td>
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<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
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<tr>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
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<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<td>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a></td>
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<tr>
<td>Phone: 678-564-1162 ext 2131</td>
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<tr>
<th>CALIFORNIA – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_content.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_content.aspx</a></td>
<td></td>
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<tr>
<td>Phone: 1-800-541-5555</td>
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<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a></td>
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<tr>
<td>Phone: 1-877-438-4479</td>
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<tr>
<td>All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<tr>
<td>Phone: 1-800-403-0864</td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP (Hawki)</td>
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<tr>
<td>Iowa</td>
<td>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
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<tr>
<td></td>
<td>Medicaid Phone: 1-800-338-8366</td>
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<td></td>
<td>Hawki Phone: 1-800-257-8563</td>
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<tr>
<td><strong>KANSAS – Medicaid</strong></td>
<td>Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a></td>
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<td></td>
<td>Phone: 1-800-792-4884</td>
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<td><strong>KENTUCKY – Medicaid</strong></td>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a></td>
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<td>Phone: 1-855-459-6328</td>
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<td></td>
<td>Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a></td>
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<tr>
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<td>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-524-4718</td>
</tr>
<tr>
<td></td>
<td>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOUISIANA – Medicaid</strong></td>
<td>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahip">www.ldh.la.gov/lahip</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-442-6003</td>
</tr>
<tr>
<td></td>
<td>TTY: Maine relay 711</td>
</tr>
<tr>
<td><strong>MASSACHUSETTS – Medicaid and CHIP</strong></td>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-862-4840</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-657-3739</td>
</tr>
<tr>
<td><strong>MISSOURI – Medicaid</strong></td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 573-751-2005</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-694-3084</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Program</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid and CHIP</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

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:

- U.S. Department of Labor
  - Employee Benefits Security Administration
  - [www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)
  - 1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)
Important Notice from Shawnee State University
About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Shawnee State University has determined that the prescription drug coverage offered by each Anthem medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Shawnee State University coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Shawnee State University coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Shawnee State University changes. You also may request a copy of this notice at any time.
For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:
- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/aso. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 639-1634 to request a copy.

### What is the overall deductible?

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Network Providers</td>
<td>$500/person or $1,000/family</td>
</tr>
<tr>
<td>In-Network Providers</td>
<td>$1,500/person or $2,500/family</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>$2,000/person or $4,000/family</td>
</tr>
</tbody>
</table>

Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

### Are there services covered before you meet your deductible?

Yes. Primary Care Specialist Visit Preventive Care for Preferred Network and In-Network Providers. Tier 1 Tier 2 Tier 3 Tier 4 Prescription Drugs for In-Network and Non-Network Providers. 

This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.

### Are there other deductibles for specific services?

No.

You don’t have to meet deductibles for specific services.

### What is the out-of-pocket limit for this plan?

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Network Providers and In-Network Providers combined</td>
<td>$3,500/person or $7,000/family</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>$6,000/person or $12,000/family</td>
</tr>
</tbody>
</table>

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
or \$8,800/family for In-Network Providers

<table>
<thead>
<tr>
<th>What is not included in the out-of-pocket limit?</th>
<th>Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants.</th>
<th>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</th>
</tr>
</thead>
</table>

| Will you pay less if you use a network provider? | Yes, Blue Access. See www.anthem.com or call (833) 639-1634 for a list of network providers. | You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-Network. You will pay the most if you use an Non-Network Provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Non-Network Provider for some services (such as lab work). Check with your provider before you get services. |

| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In Network Provider (You will pay more)</th>
<th>Non Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance/visit deductible does not apply</td>
<td>20% coinsurance/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance/visit deductible does not apply</td>
<td>20% coinsurance/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Costs may vary by site of service.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
### What You Will Pay

<table>
<thead>
<tr>
<th>Medical Event Services You May Need</th>
<th>Network Provider</th>
<th>Non Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred</strong></td>
<td>Not Applicable</td>
<td>(retail and home delivery)</td>
</tr>
<tr>
<td><strong>Common</strong></td>
<td>$10/prescription, deductible does not apply (retail and home delivery)</td>
<td>$20/prescription, deductible does not apply (home delivery)</td>
</tr>
<tr>
<td><strong>Medical Event Services</strong></td>
<td>Not Applicable</td>
<td>(retail and home delivery)</td>
</tr>
<tr>
<td><strong>Network Provider</strong></td>
<td>50% coinsurance, deductible does not apply (retail and home delivery)</td>
<td>Not covered (home delivery)</td>
</tr>
</tbody>
</table>

*See Prescription Drug section*

<table>
<thead>
<tr>
<th>If you need drugs to treat your illness or condition</th>
<th>Tier 1 - Typically Generic</th>
<th>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</th>
<th>Tier 3 - Typically Non-Preferred Brand and Generic drugs</th>
<th>Tier 4 - Typically Preferred Specialty (brand and generic)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Drug List</strong></td>
<td>Tier 1 - Typically Generic</td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
</tr>
<tr>
<td>Tier 1 - Typically Generic</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 30% coinsurance | --------none-------- |
| If you need immediate medical attention | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 30% coinsurance | --------none-------- |
| Emergency room care | $75/visit deductible does not apply | $75/visit deductible does not apply | Covered as In-Network | Copay waived if admitted. |

*For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In Network Provider (You will pay more)</th>
<th>Non Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
<td>-------none--------</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>10% coinsurance/visit deductible does not apply</td>
<td>10% coinsurance/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>-------none--------</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>-------none--------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 10% coinsurance/visit deductible does not apply Other Outpatient 10% coinsurance</td>
<td>Office Visit 10% coinsurance/visit deductible does not apply Other Outpatient 10% coinsurance</td>
<td>Office Visit 30% coinsurance Other Outpatient 30% coinsurance</td>
<td>Office Visit -------none-------- Other Outpatient -------none--------</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>-------none--------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>100 visits/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance/visit deductible does not apply</td>
<td>20% coinsurance/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance/visit</td>
<td>20% coinsurance/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
**Common Medical Event** | **Services You May Need** | **Preferred Network Provider (You will pay the least)** | **In Network Provider (You will pay more)** | **Non Network Provider (You will pay the most)** | **Limitations, Exceptions, & Other Important Information**
---|---|---|---|---|---
Skilled nursing care | 10% coinsurance | 20% coinsurance | 30% coinsurance | 100 days/benefit period for skilled nursing services.
Durable medical equipment | 10% coinsurance | 20% coinsurance | 30% coinsurance | *See Durable Medical Equipment Section*
Hospice services | No charge | No charge | No charge | **----none----**

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.**

- Acupuncture
- Dental care (Pediatric)
- Glasses for a child
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Dental Check-up
- Hearing aids
- Routine eye care (Adult)
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.**

- Bariatric surgery
- Private-duty nursing 82 visits/benefit period
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568


Does this plan provide Minimum Essential Coverage? Yes/No
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes/No
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow-up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>plan's overall deductible</strong></td>
<td>$500</td>
<td>The <strong>plan's overall deductible</strong></td>
</tr>
<tr>
<td>Specialist <strong>coinsurance</strong></td>
<td>10%</td>
<td>Specialist <strong>coinsurance</strong></td>
</tr>
<tr>
<td>Hospital (facility) <strong>coinsurance</strong></td>
<td>10%</td>
<td>Hospital (facility) <strong>coinsurance</strong></td>
</tr>
<tr>
<td>Other <strong>coinsurance</strong></td>
<td>0%</td>
<td>Other <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits *(prenatal care)*
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests *(ultrasounds and blood work)*
- Specialist visit *(anesthesia)*

This EXAMPLE event includes services like:
- **Primary care physician** office visits *(including disease education)*
- **Diagnostic tests** *(blood work)*
- **Prescription drugs**
- Durable medical equipment *(glucose meter)*

**Total Example Cost**
- Peg: $12,800
- Joe: $7,400
- Mia: $1,900

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>$500</td>
<td>$40</td>
<td>$1,200</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td><strong>$1,800</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>$0</td>
<td>$2,000</td>
<td>$100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td><strong>$2,160</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>$500</td>
<td>$0</td>
<td>$100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td><strong>$600</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkkthyes, telefononi (833) 639-1634

Amharic (አማርኛ): ከአማርኛው ከነጻ ለማስጠን ለማንኛውም ከነጻ ከአማርኛው ከነጻ ለማስጠን ለማንኛውም ለማስጠን ይፋስ ከżąኝነትና ከżąኝነትና ከżąኝነትና ከżąኝነትና ከżąኝነት (833) 639-1634.

Arabic (العربية): إذا كان لديك أي استفسارت بشأن هذا المستند، فحقق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-833-639-1634.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 639-1634:

Bassa (Bàsà Wùđù): M dyi dyi-die-die bë bëdë bá céé-dë niak ke dyi ni, s mò ni dyi-bëdënin-dë bë m kë gbo-krâ-krâ bë bô kpo dë m bëdï-wùdùën bô pidy. Bë m ke wùdù-zin-nyö dëg bë wùdù ke, ña (833) 639-1634.

Bengali (বাংলা): যদি এই লম্বায় বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসূল্য সাহায্য পাওয়া ও মুখ্য পাওয়ার অধিকার আপনার আছে। একজন দোকানীর সাথে কথা বলার জন্য (833) 639-1634 -তে কল করুন।

Burmese (မားရိုး): သင်က အားထြန်းချုပ်ရန် အားလုံးကို ဆိုရင် နှစ်ခါ ဖန်တီးခြင်း ရှိပြီးလျှင် အားလုံးကို နှိုင်းယှဉ်ပြီး ကြည့်ရှုပုံ ရရှိနိုင်ပါသည်။ (833) 639-1634

Chinese (中文)：如果您对本文件有任何疑问，您有权利使用您的语言免费获得协助和资讯。如需与译员通话，请致电(833) 639-1634。

Dinka (Dinka): Na nyol thii ne ke de ya thore de, ke yen noo log bë yë kuony kë wer alë bë geer yic yin ne thon du ke cin wëu tääü ke piny. Te kor yin ba jam wëné ran ye thok genyic, ke yen col (833) 639-1634.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 639-1634.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمکی را بدون هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-833-639-1634 تماس بگیرید.
Language Access Services:

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 639-1634.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 639-1634.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 639-1634.

Gujarati (ગુજરાતી): આ વિષયને ચાલુ કરીને, આપને તે અંગે પ્રશ્ન કરી શકી શકો, તે સાથે આપની ભાષાનામાં મહત્તમ અંગે માહિતી મેળવી શકો તમને અધિકાર છે. તેમ સાથે વાત કરવા માટે, કોલ કરો (833) 639-1634.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको तिशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुमाणियों से बात करने के लिए, कॉल करें (833) 639-1634.

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tсим xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 639-1634.

Igbo (Igbo): Ọ bụrụ na ị nwere ajiụjụ ọ bula gbasara akwụkwọ a, ị nwere ike iji鹭ụ n'ụgwọ na ozi n'asụsụ gị na akwụkwọ ụgwọ ọ bula. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 639-1634.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 639-1634.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpretor kami, hubungi (833) 639-1634.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 639-1634

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 639-1634 にお電話ください。
Language Access Services:

**Khmer** (ខ្មែរ): ប្រការប្រការលោកស្រុកគ្រូគ្រូ: នាយកដ្ឋានប្រការ្ក្សីពីការស្វែងមកប្រការ្ក្សីថ្មីដែលស្វែងមកប្រការ្ក្សីម្នាក់ស្ដីវា និងក្នុងការប្រការប្រការលោកស្រុកគ្រូគ្រូ។ សេវាកម្មនេះមានធាតុស្របក្រង់ (833) 639-1634 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata gciro. Kugira uvugishe umusemuzi, akura (833) 639-1634.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 639-1634 로 문의하십시오.

**Lao (ພາສາລາວ):** ບໍ່ເຕີມແຈ່ຍໃຈການວ່າພາສາແລະຄ່າລະເມີດໃສ່, ການມີຄວາມດົງການຫຼັງຈາກໜຶ່ງສັນຍາດຕະຫຼວດ ມະຫາວິທະຍາຍື່ນຄານປະສັນຍາດຄິດຕາມ ແລະ ເຮືອນຄົນຄອບພ່ອງກ່ວາຮຽກຮ່ວມປະເທດຂອງພວກພ𠳳. ເອລີອ ແຈ່ຍຂອງພວກພ合い (833) 639-1634.

**Navajo (Diné):** Díí náaltsoo biká’igu láhgo bina’idiikidgo ná bohó néédza dóó bee ahóot’í’ t’áá ni nízad k’ehí bee nił hodoonih táadoo bááh ilínigóó. Ata’ halne’igung la’ bíchip’i’ hadeesdzih ninizingo ko’jí’ hodiñihí (833) 639-1634.

**Nepali (नेपाली):** यदि आपके कार्यालयगत तथा जनावरीय कैसे प्रश्नों के साथ आते हैं, तो आप अपनी भाषा में मुफ्त मदद और सूचना प्राप्त कर सकते हैं। तुर्जुम परिचय नुस्तै गर्नुहुन्छ, यहाँका करोड़ (833) 639-1634.

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeaffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 639-1634 bilbilla.

**Pennsylvania Dutch (Deitsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 639-1634 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 639-1634.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 639-1634.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੂਹਾਦੀਆਂ ਧੀਂ ਰਾਸ਼ਤਰੀ ਵਿਚ ਦੋਹਾਂ ਤਕਨੀ ਦ੍ਰਿਸ਼ ਹੁੰਦੇ ਹਨ ਅਤੇ ਤੂਹਾਦੀ ਵੇਲੇ ਹੁੰੇ ਪ੍ਰਤੀ ਪ੍ਰਤੀ ਵਰਤਨ ਦੇ ਨਾਲ ਵੀ ਪ੍ਰਤੀ ਵਰਤਨ ਦੇ ਅਧਿਆਵਾਂ ਦਾ ਜ਼ੋਰ ਹੈ। ਪ੍ਰਤੀ ਪ੍ਰਤੀ ਵਿਚਕਾਰ ਵੀ ਵਰਤਨ ਅਧਿਆਵਾਂ ਦੀ, (833) 639-1634 ਤੇ ਵਾਲੋ ਵਚੋ।
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 639-1634.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

Samoan (Samoa): Afae e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 639-1634.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 639-1634.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 639-1634.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

Thai (ไทย): หากคุณมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 639-1634 เพื่อพบคุณกับลำ

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зв'яжіться з номером (833) 639-1634.

Urdu (اردو): اگر اسم بستیوی زندہ کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے، کیسی ملتوی سے بات کرنے کے لئے (833) 639-1634 الگ ہو سکتا ہے۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

Yiddish (אידיש): נאיב איר עמירא שאלת וויי דעם דאקומענט, נאיט איר לי רעסן, די ביזוקקנעץ דעס איניערמארץ איזעיאיר שפערקאר לאיס פירס, צא רעדן צא.

Yoruba (Yorùbá): Ti o bá ní ëyíkèyì ìbèrè nipa àkọṣìlè yìì, o ní ẹ̀rọ́ láti gba iiranwò àti àwíwáà ní èdè ré ìwòjú. Bá wa ọgbùfù kan ìwòjú, pe (833) 639-1634.
Language Access Services:
It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** 07/01/2020 - 06/30/2021  
**Coverage for:** Individual + Family  |  **Plan Type:** PPO + HSA

### Shawnee State University: Anthem Blue Access PPO (3-Tier) HSA with National Rx Formulary

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (833) 639-1634 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| What is the overall deductible?      | $3,000/person or $6,000/family for Preferred Network Providers and In-Network Providers combined.  
$6,000/person or $12,000/family for Non-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes, Preventive Care for Preferred Network and In-Network Providers. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $6,000/person or $12,000/family for Preferred Network Providers and In-Network Providers combined.  
$12,700/person or $25,400/family for Non-Network Providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network | Yes, Blue Access. See [www.anthem.com](http://www.anthem.com) or call (833) | You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-Network. You will pay the most if you use an Non-Network Provider, and you... |
**Provider?**
639-1634 for a list of network providers.

Some might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an Non-Network Provider for some services (such as lab work). Check with your provider before you get services.

<table>
<thead>
<tr>
<th>Do you need a referral to see a specialist?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
</tr>
<tr>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In Network Provider (You will pay more)</th>
<th>Non Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>Not Applicable (retail and home delivery)</td>
<td>$10/prescription (retail) and $20/prescription (home delivery)</td>
<td>40% coinsurance (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>Not Applicable (retail and home delivery)</td>
<td>$35/prescription (retail) and $70/prescription (home delivery)</td>
<td>40% coinsurance (retail) and Not covered (home delivery)</td>
<td>*See Prescription Drug section</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>Not Applicable (retail and home delivery)</td>
<td>$60/prescription (retail) and $120/prescription (home delivery)</td>
<td>40% coinsurance (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>National Drug List</td>
<td>Tier 4 - Typically <strong>Preferred Specialty</strong> (brand and generic)</td>
<td>Not Applicable (retail and home delivery)</td>
<td>25% <strong>coinsurance</strong> up to $250/prescription (retail and home delivery)</td>
<td>40% <strong>coinsurance</strong> (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>$75/visit</td>
<td>$75/visit</td>
<td>Covered as In-Network</td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 10% <strong>coinsurance</strong></td>
<td>Office Visit 10% <strong>coinsurance</strong></td>
<td>Office Visit 40% <strong>coinsurance</strong></td>
<td>Office Visit <strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td>If you need help recovering or</td>
<td><strong>Home health care</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>100 visits/benefit period.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td><strong><strong><strong>none</strong></strong></strong>*</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In Network Provider (You will pay more)</th>
<th>Non Network Provider (You will pay the most)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

### What You Will Pay

<table>
<thead>
<tr>
<th></th>
<th>-limitations, exceptions, &amp; other important information</th>
</tr>
</thead>
</table>

#### Preferred Network Provider (You will pay the least)

- **Skilled nursing care**
  - 10% coinsurance
- **Durable medical equipment**
  - 10% coinsurance
- **Hospice care**
  - 10% coinsurance

#### In Network Provider (You will pay more)

- **Skilled nursing care**
  - 20% coinsurance
- **Durable medical equipment**
  - 20% coinsurance
- **Hospice care**
  - 10% coinsurance

#### Non Network Provider (You will pay the most)

- **Skilled nursing care**
  - 40% coinsurance
- **Durable medical equipment**
  - 40% coinsurance
- **Hospice care**
  - 100 days/benefit period for skilled nursing services

*See Durable Medical Equipment Section*

#### Limitations, Exceptions, & Other Important Information

- 100 days/benefit period for skilled nursing services.
- **100 days/benefit period for skilled nursing services.**

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Pediatric)
- Glasses for a child
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Dental Check-up
- Hearing aids
- Routine eye care (Adult)
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Routine foot care

#### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric surgery
- Private-duty nursing 82 visits/benefit period
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
Does this plan provide Minimum Essential Coverage? Yes/No
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes/No
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in network prenatal care and a hospital delivery)

- The plan's overall deductible: $3,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn't covered**: Limits or exclusions $60

**The total Peg would pay is**: $4,400

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Managing Joe’s type 2 Diabetes
(a year of routine in network care of a well controlled condition)

- The plan's overall deductible: $3,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**: Limits or exclusions $60

**The total Joe would pay is**: $5,160

### Mia’s Simple Fracture
(in network emergency room visit and follow up care)

- The plan's overall deductible: $3,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**: Limits or exclusions $0

**The total Mia would pay is**: $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 639-1634

Amharic (አማርኛ): ከለ龠 ከፈይ እርዳታ ከኽልድ እና በተለያዩ ከበታ ከችረ ከር ከመልከት ከም ላይ ከንግድ ከምር ከቋ ላይ ከተለያዩ ከመልከት ከም ላይ ከንግድ ተስተ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ ከንግድ ከሚካ (833) 639-1634.

Arabic: (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند, فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1634-639 (833).

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկությունները ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 639-1634:

Bassa (Bäsɔ Wùqìn): Mi dyi dyi-dié-dê bê bé dé há céé-dê niâ ke dyi ni, o mô ni dyi-bëdéén-dê bê m ke gbo-kpá-kpá ke bô kpô dé m bidj-wùqûn bô pidiy. Bê m ke wùqû-zîn-nyo do gbo wùqû ke, da (833) 639-1634.

Bengali (বাংলা): যদি এই লিথিয়ের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিলাসূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোকানীর সাথে কথা বলা জন্য (833) 639-1634 -তে কল করুন।

Burmese (ဗမာ): ဗမာစာအုပ်ဖူး ပြုလုပ်သော အမှားကြောင်း ကျောင်းသော အားသက်သော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားသော သောစားtı.

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 639-1634。

Dinka (Dinka): Na nong thiicc nê ke de yâ thôrê, ke yin noq lôq bê yi kuony ku wer akê bê geêr yic yin ne thôŋ du ke cîn wêu tâuâ ke pînî. Te kôr yin bâ jam wênê ran ye thêk geryíc, ke yin cîl (833) 639-1634.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 639-1634.
Language Access Services:

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 639-1634.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 639-1634.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε τη δυνατότητα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνεύ, τηλεφωνήστε στο (833) 639-1634.

Gujarati (ગુજરાતી): જે આ દસ્તાવેજ અંગે આપને ક્રીયાપ્રદ પ્રશ્નો હોય તો, ક્રીયાપ્રદ અંગે આપની ભાષામાં મદદ અને માહહતી મેળવવાનો તમામ અધિકાર છે. દુસ્રાધિન્થી સાથે વાત કરવા માટે, કોલ કરો (833) 639-1634.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

Hindi (हिंदी): आप अपो से पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको तिशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुसराधिकारी से बात करने के लिए, कॉल करें (833) 639-1634.


Igbo (Igbo): Ọ bùrọ na i nwere ajiụ ajụ bula gbasara akwụkwọ a, i nwere ikeji ińweta enyemaka na ozi n'asụsụ gị na akwu ụghọ ọ bula. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 639-1634.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 639-1634.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 639-1634.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 639-1634.

Japanese (日本語): この文書についての不完全な点がある場合、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話し合います。(833) 639-1634 にお電話ください。
Language Access Services:

**Khmer (ខ្មែរ):** ប្រើប្រាស់ភាសាខ្មែរក្នុងការសិក្សា: ក្នុងផ្ទៃក្តីសិក្សាពីរៀននេះអាចជួយនឹងការសិក្សារបស់អ្នកដូចជាសេដ្លៀរ និងការប្រការពីច្បាប់ ឬការសិក្សាទូលេះ។ (833) 639-1634

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 639-1634.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 639-1634 로 문의하십시오.

**Lao (ภาษาลาว):** ถ้าคุณมีข้อสงสัยเกี่ยวกับเอกสารนี้, คุณสามารถขอความช่วยเหลือได้ตลอดเวลา ด้วยการติดต่อเราที่ (833) 639-1634.

**Navajo (Diné):** Díi naaasooos biká’įgií lahgo bina’idilkidgo ná bohóóñedzá dóó bee ahóot’í’ t’áá ni nízáad k’ehjí bee nił hodoonih t’áadoo bááh’ iliniigóó. Ata’ haln’égií la’ bich’į’ hadeedsihi ninízingo kojí hodílnih (833) 639-1634.

**Nepali (नेपाली):** यदि आपकालाई तपाईंले केही प्रश्न प्रस्तुत गर्नुभए, आफ्नो भाषामा निष्क्रिय रस्मिय रूपमा जानकारी प्राप्त गर्न भएनु तपाईंलाई टर्जुमाए भएको छ। दोमाछिसेखवुलू सुन्ताना ताँग, यहाँ कल गुणोत्तर (833) 639-1634

**Oromo (Oromifaa):** Sanadi kanaa wajii wajin walqabaate gaffi kamilyuu yoo qabduu tanaaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaq qabdaa. Turjumaama dubaachuuf, (833) 639-1634 bilbilla.

**Pennsylvania Dutch (Deitsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griee in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 639-1634 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 639-1634.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 639-1634.

**Punjabi (ਪੰਜਾਬੀ):** ਤੁਹਾਨੂੰ ਤੁਹਾਨੂੰ ਲਿਖ ਸਕਦੇ ਹਨਵੇਂ ਕਿਸੇ ਮਜ਼ਬੁੱਤ ਦ੍ਰੁ ਹਨ ਜਾਂ ਤੁਹਾਨੂੰ ਤੁਹਾਨੂੰ ਲਿਖ ਸਕਦੇ ਹਨ ਵੀ ਤੁਹਾਨੂੰ ਤੁਹਾਨੂੰ ਪ੍ਰਭਾਵਨਾਮੀ ਵਧਾਣ ਦੀ ਅਧਿਕਾਰ ਪੂਜਊਂਦੇ। ਫੀਲਾ ਸੁਸਾਇਡਿਟੀ ਰਾਸ਼ੀ ਖਾਰ ਕਰਨ ਲਈ, (833) 639-1634 ਤੇ ਤਬਦੀਲ ਕਰਨ।
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpet, contactați telefonic (833) 639-1634.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 639-1634.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 639-1634.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 639-1634.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

Thai (ไทย): หากท่านมีคำถามใดๆ!เกี่ยวกับเอกสารฉบับนี้!ท่านมิได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย!โดยโทรศัพท์! (833) 639-1634 เพียงพูดคุยกับล่าม!

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зв'яжіться по номері (833) 639-1634.

Urdu (اُردُو): اگر اس دستاویز کی بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد آور اپنی زبان میں مفت معلومات حاصل کرNão کے لئے اپنے حاصل کرNão کے لئے کسی متوجہ سے بات کرنا کے لئے (833) 639-1634 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

Yiddish (אידיש): צו אירא, יאכע אטנא שייטלאן, או די ענבר איטנבראָמען, היטן איר די רעטו, צו בּאָקון metod אינטארדישטע אַיוניוו שופארק ען קלי, פאַן. זא רעדל, זא

Yoruba (Yorùbá): Tí o bá ní ìyìkèyì ìbèrè nipa àkọṣèlè yì, o ní ètò látì gba iànáwò àti ìwìtàn ní èdè ní ìlòìfè. Bá wa ògbùfù kàan sòrò, pe (833) 639-1634.
Language Access Services:
It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Shawnee State University Human Resources Department 940 Second Street Portsmouth, OH 45662–4344, or by telephone at (740) 351–3484.

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
### PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shawnee State University</td>
<td>31-0864917</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>940 Second Street</td>
<td>(740) 351-3484</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portsmouth</td>
<td>Ohio</td>
<td>45662-4344</td>
</tr>
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</table>

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<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources Department</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Phone number (if different from above)</th>
<th>12. Email address</th>
</tr>
</thead>
</table>

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

- **As your employer, we offer a health plan to:**
  - [x] All employees. Eligible employees are:
    - All eligible Full-time employees
  - [ ] Some employees. Eligible employees are:

- **With respect to dependents:**
  - [x] We do offer coverage. Eligible dependents are:
    - Spouses and dependent children to age 26
  - [ ] We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.