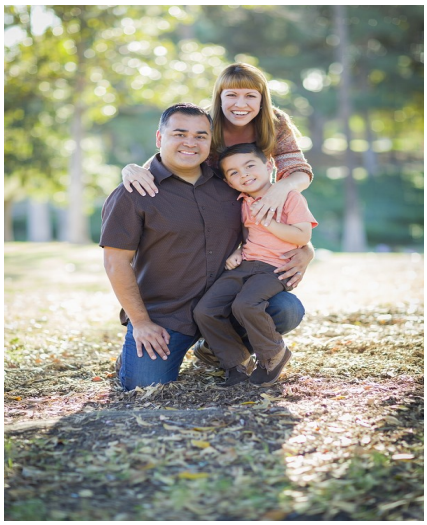
2021

BENEFITS GUIDE

STEPS FOR LIVING WELL.



Spring Arbor
UNIVERSITY

BENEFITS TO MEET THE NEEDS OF YOU & YOUR LOVED ONES

Working Together for Better Health

It is because of our employees that we are a successful organization. Each year, we design our benefits program offering to ensure that we provide all the essential resources for you and your family. It is our priority to help our employees have what they need to live a healthy, happy life.

We strive to offer a variety of benefit choices and resources to help you be the best person and employee. Take time to learn and understand what is available. These services are available to help you live and manage in today's complex world.

Review this guide for more information on the benefits available for you and your loved ones in 2021. Refer back to this guide throughout the year when you have additional questions on your benefits.

ABOUT THIS GUIDE

This Guide contains the benefit overview details of the full benefits package offered to you as an SAU employee. For more information, visit the Portal. Please contact Human Resources if you have any questions.

Not all benefits, limitations and exclusions of the benefit programs are listed. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. SAU reserves the right to amend, modify or terminate any plan at any time and in any manner.

WHAT'S INSIDE

Medicare Notice of Creditable Coverage

If you (and/or your eligible dependents) are currently Medicare eligible or will become Medicare eligible during the next 12 months, the prescription drug coverage that you elect from SAU under the Blue Cross Blue Shield plans are creditable (as valuable) as Medicare's prescription drug coverage.

For more information, review the Plan's Medicare Part D Notice of Creditable Coverage found on page 28.

A CHECKLIST FOR A SUCCESSFUL ENROLLMENT

Step 1: DISCOVER

Your Options

- ☐ **Read this Guide** and keep it handy so you can refer to it as needed. For more details, please visit the Portal to reference the carrier documents.
- ☐ **View the recorded Open Enrollment presentation and** other resources on the Spring Arbor HR Portal.
- ☐ **Ask Questions.** Contact Spring Arbor Human Resources—SpringArbor.HR@arbor.edu or 517-750-6575 for answers to your questions, if needed.
- ☐ **Sign Up** for a Paycor login if you do not have one.

Step 2: ORGANIZE

For Enrollment

- ☐ **Consider your current benefit coverage and whether or not it will meet your needs for the upcoming year.** For example, are you expecting a major medical expense, such as childbirth or an elective surgery? Is your family financially protected if you can't work due to an accident or illness?
- ☐ **Consider other available coverage.** If your spouse works and has access to benefits through his or her employer, carefully review the coverage available and compare it to SAU's benefits to determine which plan best meets your needs.
- ☐ **Gather information you'll need.** If you are adding new dependents, you will need their dates of birth and Social Security Numbers. You will also need to provide proof of your relationship to Human Resources by **November 13, 2020**.
- ☐ **If you need additional assistance,** sign up for a Virtual 30 minute HR Help Session.

Step 3: ENROLL

Benefit Advisor

- ☐ **NEW Enrollment Process:** starting this Open Enrollment period, Spring Arbor University will be enrolling online through the Benefits Advisor portal provided by Paycor **(www.paycor.com)**. Supporting your wellbeing through your benefit elections is one of the most important decisions you make. Invest the time to do it thoughtfully.
  - **Access Benefits Advisor & Begin enrollment** (review instruction guide as needed)
  - **Verify your personal & dependent information—**make sure you have it to enroll
  - **Navigate the Plan pods & Enroll in a plan**
  - **Make sure to add the appropriate beneficiaries**
  - **Review & Confirm your elections**
  - **Email or Print and Save Your Confirmation Statement**
- ☐ **Enroll by November 13, 2020.** Submit the required information via the Benefits Advisor platform

2021 CONTRIBUTION RATES

MONTHLY RATES	EE Only	EE + One	Family
Medical—Option 1	$108.82	$253.88	$316.06
Medical—Option 2	$48.66	$113.16	$140.80
Dental	$41.02	$77.28	$153.40
Vision	$6.76	$12.83	$18.84

ELIGIBLITY FOR SAU BENEFIT PLANS

Who is Eligible

Employees assigned to work 30 hours per week or equivalent teaching load for full-time status classification.

All benefit elections are made independent of one another. If you elect coverage, your dependents are also eligible for medical, dental, vision and voluntary life and AD&D or Aflac insurance coverage. Eligible dependents include:

- ❑ Your legal spouse
- ❑ Your children (including your adopted, biological, foster, and step-children) up to the end of the month in which they turn 26 for the medical, dental, vision, and life insurance plans
- ❑ Children up to age 26 for whom you have legal guardianship over. They must live with you, be financially dependent on you, and were under 18 years old when you obtained guardianship.
- ❑ Mentally or physically disabled children of any age if they rely on you for support and became disabled before age 26. Proof of disability will be required under the medical plan.

It is your responsibility to ensure your dependents meet the above requirements. If your dependent becomes ineligible during the plan year, you must notify Spring Arbor University within 30 days. You must also provide Social Security numbers for dependents enrolled in coverage.

When Coverage Begins

Current Enrollees: The coverage options you elect during open enrollment will become effective January 1st.

New Hires: Benefits are effective on the 1st day of the month following your date of hire, unless you are hired on the first of the month. You must complete the enrollment process during your initial eligibility period if you want to have coverage. If you fail to enroll during this period, you will only have the company paid Basic Life/AD&D and Long Term Disability coverages.

When Coverage Ends

Your medical, dental and vision benefits coverage will end on the last day of the month and your life and disability coverage the last date in which:

- ❑ You are reclassified to an ineligible status
- ❑ Your employment with SAU ends due to resignation, termination or death; or
- ❑ You stop paying your share of the coverage.

Your dependent(s) coverage ends:

- ❑ When your coverage ends; or
- ❑ For Spouse: Date of the life qualifying event (e.g. divorce) or eligibility through an employer sponsored plan
- ❑ For Legal Child(ren) (up to age 26): The end of the month in which they turn 26.

Gaining Medicare Eligibility

Medicare eligibility requirements and categories vary depending on an individual's situation. Many people are eligible to enroll in Medicare at age 65 and may enroll during the seven-month period surrounding your 65th birthday.

When you become eligible for Medicare, your current coverage and premium costs under Spring Arbor University does not change. Your SAU coverage will be your primary insurance, meaning that claims are first processed through SAU. If any services are covered by Medicare, Medicare will pay as a secondary insurance.

Once enrolled in Medicare, your pretax elections to an HSA must cease.

READY TO ENROLL?

Changing Your Coverage

Spring Arbor University sponsors a program that allows you to pay for certain benefits using pre-tax dollars. IRS regulations state that you cannot change benefit selections during the year unless you experience a qualified change in status or special enrollment period, such as marriage, birth or adoption of a child, or loss of other coverage.

If you experience a qualified change in status, you will be able to make changes to your benefit elections. You will be required to provide verifying documentation for new dependents or events to support the change. For example, if you get married and want to add your spouse to your medical coverage, you will be required to provide a marriage certificate. You are required to submit documentation to Human Resources within **30 days** of the event in order to make changes. Otherwise, you will be required to wait until the next Open Enrollment period to make changes.

All elections will remain in effect through the end of the plan year, December 31st. Because of the limited opportunities to make changes during the year, it is important that you make your elections carefully.

Spring Arbor University: Pre & Post Tax Options

Due to the nature of the Spring Arbor University Section 125 plan, we offer benefit on a pre-tax basis. An additional benefit of making pre-tax benefit selections is that premiums are taken from an employee's gross compensation before any applicable state and federal taxes have been deducted.

Spring Arbor does offer its employees the option to select certain benefits on a post-tax basis. This means that premiums are deducted from an employee's net pay after the applicable state and federal taxes have been deducted.

Please be aware of the difference when selecting benefits in the Benefits Advisor portal.

Adding a New Dependent?

If you are adding a new dependent for coverage, you must provide proof of eligibility to Human Resources by November 13, 2020. Failure to provide this information will result in the dependent(s) not being covered in 2021.

SAU and our providers perform plan audits to main in compliance with plan guidelines. If we find you are covering an ineligible dependent, that dependent will be removed (and will not be considered a qualifying event) and you could be found responsible for claims paid while that member was covered.

Proof documents required (copies please; no original documents):

Spouse 	Marriage certificate
Child(ren) 	Birth certificate listing the employee as the parent; or Birth certificate listing the employee's spouse as the parent (if spouse has not been verified, above proof is also required); or Court paperwork documenting adoption, legal guardianship or foster child relationship; or QMCSO listing the employee as responsible for benefit coverage.

MEDICAL PLAN OPTIONS

SAU's medical and prescription plans are administered by Blue Care Network (BCN). The plans provide comprehensive coverage to help keep you and your family healthy.

BCN HMO Plans Key Features:

- Require a primary care physician (PCP) selection and obtain referrals for specialist care
- Preventive exams and screenings with in-network providers are covered at 100 percent without satisfying the deductible
- Copays and coinsurance, including pharmacy, apply after meeting the deductible
- Access to a Health Savings Account (HSA)
- Coverage at non-participating hospitals is limited to services needed to treat an accidental injury or medical emergency. There is NO COVERAGE for non-emergency hospital services or services received at mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

How to find a provider:

- Visit bcbsm.com
- Click on "Find a Doctor"
- Select "Search without logging in."
- Change Your Location and Your Plan (BCN HMO) on the top toolbar
- Select a category, then search by doctor name or specialty

	Option 1	Option 2
Deductible Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.	$2,000/Individual $4,000/Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$3,000/Individual $6,000/Family
HRA Threshold Deductible expenses incurred greater than the threshold are submitted to BASIC for reimbursement of $500/$1,000.	$1,500/Individual $3,000/Family	$2,500/Individual $5,000/Family
Out-of-Pocket Maximum These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates.	$3,000/Individual $6,000/Family	$6,350/Individual $12,700/Family
Preventive Services—deductible does not apply	Covered at 100%	Covered at 100%
Office Visit – Primary Care	80% after deductible	80% after deductible
Office Visit – Specialist	80% after deductible	80% after deductible
Diagnostic Labs, X-ray and Pathology	80% after deductible	80% after deductible
Hospital Services – Inpatient Care and Surgery	80% after deductible	80% after deductible
Emergency Room	80% after deductible	80% after deductible
PRESCRIPTION DRUGS		
Retail—30 day supply	Tier 1A - $10 after deductible Tier 1B - $30 after deductible T2- $60 after deductible T3- $80 after deductible T4- 20% coinsurance after deductible (max $200) T5- 20% coinsurance after deductible (max $300)	Tier 1A - $10 after deductible Tier 1B - $30 after deductible T2- $60 after deductible T3- $80 after deductible T4- 20% coinsurance after deductible (max $200) T5- 20% coinsurance after deductible (max $300)
Mail Order: 31-90 day supply	3x's the 30 day copay/coinsurance minus $10 after deductible	3x's the 30 day copay/coinsurance minus $10 after deductible

MEDICAL PLAN INFORMATION

With this medical plan, the benefits are not paid (medical or prescription drug) until you have satisfied the deductible. Once the deductible has been satisfied, the plan begins to pay a set percentage *(coinsurance)* for covered services. **(HDHPs do not have office visit, urgent care visit or emergency room visit copays; such charges apply first towards the deductible and then towards coinsurance. Prescription drugs are subject to the medical deductible. Once the medical deductible is met, the applicable prescription drug copays apply with the exception of the drugs included on the Preventive Drug List which are only subject to the applicable copay.)** The exception to this rule is preventive care benefits. Blue Care Network has a schedule of preventive care services that are payable at 100% with no deductible or cost sharing when they are performed in-network.

Option 1 in-network deductible is $2,000 for a single contract and $4,000 for a family contract. Option 2 in-network deductible is $3,000 for an individual and $6,000 for a family. However, there is a Health Reimbursement Account (HRA) administered by BASIC that will provide you reimbursement for any deductible expense over the deductible threshold. Option 1's threshold is $1,500 for a single contract and $3,000 for a family contract. Option 2's threshold is $2,500 for an individual and $5,000 for a family contract. After you satisfy the deductible, the plan will begin to pay 80% of approved in-network services, and you will be responsible for 20% up to the in-network out-of-pocket maximum. After which the plan will pay for allowed services at 100%.

Primary Care Physician (PCP)

Each member on your plan will need to designate a primary care physician. If you do not make a designation at the time of enrollment, one will be assigned and you will receive that notification in the mail. You have the ability to change your PCP on a monthly basis by contacting BCN Customer Service.

To receive care from a specialist, you will need to receive a referral from your PCP. The referral will be a global referral, meaning once your provider has provided a referral, you will only need to recertify once that referral has been exhausted. This may mean a recertification only once a year.

Women have the ability to self-refer to an OBGYN. A referral from a PCP is not required. However, women will want to make sure that the selected OBGYN remains in-network with BCN.

ID Cards

When you first enroll in coverage or if you change plans during Open Enrollment, you will receive an ID card. Look for your new ID cards to arrive prior to your coverage effective date. You will receive one card per enrolled member. Show your new ID cards at your first visits in the new year.

What Does "Embedded" Mean?

If your plan has an embedded deductible, such as Option 2, benefits for that individual are payable once any individual satisfies the individual deductible, even on family coverage. With the out-of-pocket maximum, that means that any single individual, even on family coverage, cannot have claims that exceed the individual in-network out-of-pocket maximum and, if multiple members of your family accrue large claims, you'll still be protected by the family in-network out-of-pocket maximum.

For example, an employee, his wife, and daughter are on the Option 2 plan with family coverage, which has a $6,000 family embedded deductible, and the individual deductible is $3,000. The daughter incurs $3,000 in medical bills, so her deductible is met. The plan will help pay any subsequent covered medical expenses for the daughter that year even though the family deductible has not been met yet.

On the other hand, if the option you choose does not have an embedded deductible, such as Option 1, the plan begins paying only once a single person, or a combination of family members, meet the full family deductible.

PRESCRIPTION DRUG COVERAGE

Prescription drugs are covered as part of your medical plan and also administered by BCN.

Custom Formulary
Most health plans, including the one SAU offers, have a drug formulary. A drug formulary is a list of prescription drugs that are preferred by the health plan. The purpose of a drug formulary is to steer you to the least costly medications that are sufficiently effective for treating your health condition. Your prescription drug payment responsibility is based on the designated "tier" where your drug resides on the formulary list. You will pay more if your medication is a non-preferred drug or is not covered by the formulary. To find your medications on the BCBSM Custom Formulary, log on to www.bcbsm.com and enter "Drug List" in the Search box in the upper right corner of the webpage.

Prior Authorization / Step Therapy
When a doctor prescribes certain expensive, brand name drugs, BCBSM has prior authorization and step therapy guidelines that require prior approval before they will be covered. Under these programs you may be required to try a more cost effective or less risky medication in the same drug class first. Details about which drugs require Prior Authorization or Step Therapy are available in the BCBSM Custom Formulary.

Mandatory Maximum Allowable Cost Drugs
If your doctor requests and receives prior authorization from BCBSM for a formulary or non-formulary brand name drug with a generic equivalent and writes "Dispense as Written" or "DAW" on the prescription order, you pay only the copay. Otherwise, if your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you must pay:

- the difference in cost between the approved amount for the brand-name drug and the maximum allowable cost for the generic drug; **plus**
- Your applicable payment responsibility.

Mail Order Prescription Drug Program
The Mail Order Prescription Drug Program enables you to refill many of the medications you take on an on-going basis. Using the mail order program, you can obtain a 90-day supply of your maintenance medication for a copay that equals a single 30-day retail pharmacy copay. Your medications will be mailed to your home, with free standard shipping.

Specialty Drugs
Alliance RX Walgreens Prime handles all mail-order requests for specialty drugs only. BCN will not pay for more than a 30-day supply of a covered specialty pharmaceutical. Exceptions may be made if a member requires more than a 30-day supply. For general benefit information, please call Alliance RX Walgreens Prime Customer Service at (866) 515-1355 or visit the website at www.alliancerxwp.com.

You may also receive specialty prescriptions at one of the following Walgreens pharmacies: Walgreens Retail Pharmacy or Walgreens Community-Based Specialty Pharmacy.

TELADOC

We all have busy schedules. Seeing a doctor when you need to can be tough. Teladoc is a service that allows you resolve your medical issues with U.S. board-certified doctors, 24/7, via telephone or online video consultations. Teladoc is not a substitute for the regular care of your doctor or if you have a serious medical emergency.

When is a good time to use Teladoc?

- If you're having trouble getting in to see your regular doctor
- If you're thinking of going to urgent care or the ER for a non-emergency issue
- When you're on vacation, on a business trip, or away from home
- If you need a short-term prescription refill
- If you'd like your lab results analyzed
- If you have a health-related question
- If you'd like a medical issue explained to you or you need a second opinion

Step 1. Medical history

You will need to complete your medical history online before requesting a consult.

Step 2. Request consult

Log on to your account or call Teladoc 24/7/365, to request either a telephone or video consultation.

Step 3. Talk with a physician

A board-certified physician licensed in your state reviews your medical history and provides a consultation over the phone or through video, just like an in-person visit.

Step 4. Resolve the issue

The physician recommends the right treatment for your medical issue. If a prescription is necessary, it is electronically sent to your pharmacy of choice.

Step 5. Continuity of care

The physician documents the results of the consultation in your medical history. Consultation information can be sent to your primary care physician.

How much does it cost? There is no cost to you for Teladoc consultations.

What conditions does Teladoc treat?

Common conditions include sinus problems, respiratory infection, allergies, urinary tract infection, cold and flu symptoms, poison ivy, pink eye and many other non-emergency illnesses.

FINANCIAL

HEALTH SAVINGS ACCOUNT (HSA) FAQS

How does it work?

If you elect the medical plan, you may be eligible to contribute to a health savings account (HSA). To fully open your account, you will need to complete and submit the County National Form and return it completed to HR. They will use that form to notify payroll of your desired deduction and share it with County National. County National will mail your debit card directly to your home. Should you want to modify your election amount during the year, please contact HR.

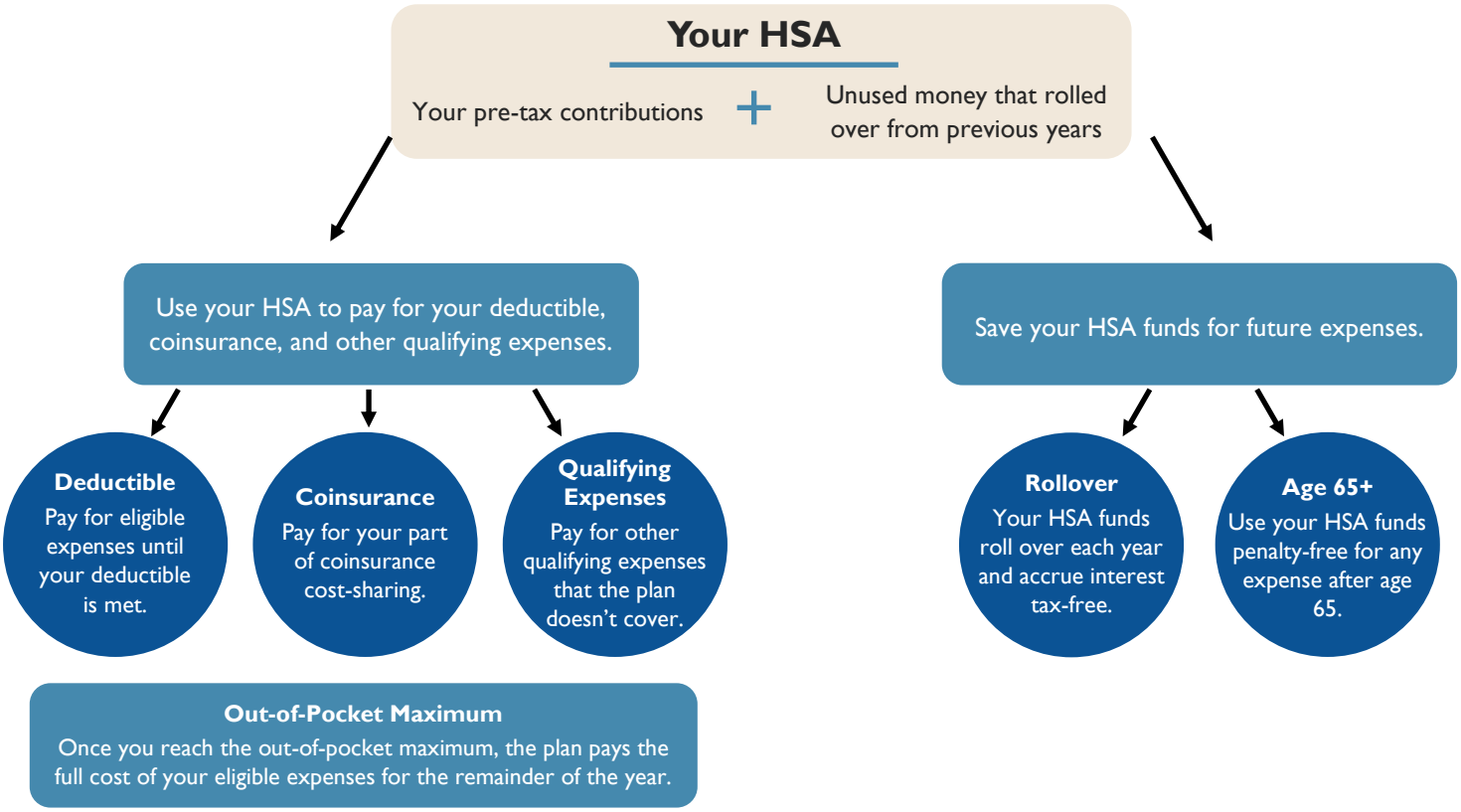
The HSA, allows you to save pre-tax dollars for use on health expenses now or in the future. You can use your HSA to cover health care expenditures, including deductibles, prescriptions, out-of-pocket medical expenses, dental care, and vision care for you, your spouse, and eligible tax dependents. The HSA is yours, regardless of future changes in employment, and any money remaining in your HSA at the end of the year rolls over, allowing you to accumulate significant savings.

Note: The IRS has its own definition of a dependent eligible to use the HSA. For more information, please refer to the section titled, "Distributions from an HSA" of IRS Publication 969.

Key Features:

- Contributions are taken pre-tax from your paychecks and deposited into your account
- Your account earns interest or can be invested to grow tax-free
- Withdrawals for qualified medical expenses are made tax-free
- Funds roll over each year
- 2021 contribution limits:
  - Single coverage: $3,600
  - Family coverage: $7,200
  - Catch-Up contribution (Age 55+): $1,000
- It is not recommended to utilize HSA funds for expenses that will be reimbursed by HRA funds due to possible tax implications according to IRS guidelines.

A Closer Look at the HSA



Can everyone participate in the HSA?

No, not everyone. The Internal Revenue Code says to participate in a HSA, individuals must be enrolled in a "qualified" High Deductible Health Plan (like the one we offer at SAU), they cannot be a dependent on another person's tax return, and they cannot be covered by another non-qualified medical plan. Individuals are not eligible to contribute to both the HSA and a Health Care FSA (or a spouse's Health Care FSA). Additionally, you cannot contribute to a HSA if you have received VA medical benefits in the previous three months, or if you are enrolled in Medicare.

How do I contribute to an HSA?

You can choose to contribute via pre-tax payroll deduction, or you can deposit lump sum amounts (post-tax) into your HSA then take the tax deductions at the end of the year when you file your income tax return.

What kind of health expenses can be paid for with HSA funds?

Eligible or "qualified" expenses are defined by Section 213(d) of the IRS Tax Code. They are the same expenses that are eligible for reimbursement under a Health Care FSA (see IRS Publication 502).

It is not recommended to utilize HSA funds for expenses that will be reimbursed by HRA funds due to possible tax implications according to IRS guidelines.

What if I start an HSA now, but lose eligibility later because I enroll in a non-qualified plan?

You need to be covered by a qualified plan in order to contribute to your HSA. So if you gain coverage under another plan that doesn't qualify, you'll need to stop making contributions to your HSA. You can still use the funds in your HSA for qualified expenses, even if you may not be eligible to contribute to one.

Can I use the money in my HSA to pay for qualified expenses for my spouse or child?

Yes, you can spend your HSA dollars on qualified expenses for yourself, or anyone you claim as a spouse or dependent on your personal income tax—even if that person is not enrolled on your medical plan.

Does the HSA earn interest?

Yes! This is one of the best features of a HSA. Deposits are held in an interest-bearing checking account. Individuals can also choose to invest the funds. The earnings accumulate tax free, and as long as the money in the account is used to pay for qualified expenses, account holders will never pay taxes on the money deposited or the interest or earnings gained. SAU pays the HSA administrative fee on your behalf while you are an active employee.

What happens after I turn 65, or enroll in Medicare?

You will not be able to contribute to an HSA once you enroll in Medicare; however, you will be able to continue to use the money in your account to pay for eligible medical expenses as well as Medicare or long term care insurance premiums. Generally, this means that at age 65 you are no longer able to contribute, since most individuals enroll in Medicare Part A (hospital) at no cost upon turning 65. It is **your** responsibility to stop your HSA deductions.

Do I have to keep records about my HSA?

Yes, you need to keep complete records so you can show the IRS that you've used the money in your account to pay for qualified expenses in the even of an audit. You should keep a record of all deposits and expenditures, and save all receipts. These records are subject to IRS audit, so keep everything in a safe place. SAU nor the bank housing your HSA will have information regarding distributions from your HSA.

What happens if I use the money in my HSA for a non-qualified expense?

Money in your HSA is not taxed when used for qualified health expenses. If you use your funds for non-qualified expenses, a 20% penalty plus regular taxes apply. Once you reach age 65, withdrawals for non-qualified expenses are taxable, but no penalty applies.

Can I use my HSA for Over The Counter (OTC) Medications & Items?

Over-the-counter medications are reimbursable without a prescription per the CARES Act of 2020. Menstrual products are now qualified expenses as well.

DENTAL

Visiting a dentist every six months might not be your favorite way to spend an hour, but it might be one that saves your life. During routine checkups, dentists look for more than cavities and gum disease—they look for signs of other serious health conditions like heart disease and diabetes.

Mouth maintenance is not only good for your smile; it just might be a life saver!

SAU's dental plan is administered by **Delta Dental of Michigan.** Keep in mind that Delta classifies dentists into three networks.

Delta PPO

- Claim paid based on the Delta approved amount, plus a PPO Provider discount is applied
- Provider cannot balance bill the patient

Delta Premier

- Claim paid based on the Delta approved amount
- Provider cannot balance bill the patient

Non-participating

- Claim paid based on the Delta approved amount
- Provider can balance bill the patient for the difference between their fees and Delta's approved amount

ITEM/SERVICE	COVERAGE
Deductible (waived for Tier 1 and Tier 4)	$50 per person (max of $150 per family)
Annual Maximum Benefit (does not apply to Tier 1 or Tier 4)	$1,000 per person
Maximum Carryover	$1,200 ($350 added each year one service of less than $500 paid that year)
Orthodontia Lifetime Maximum	$1,000 per person
Tier 1: Diagnostic & Preventive Services	Plan pays 100% / You pay $0
Tier 2: Basic Services	Plan pays 80% / You pay 20%
Tier 3: Major Services	Plan pays 50% / You pay 50%
Tier 4: Orthodontic Services (to age 19)	Plan pays 50% / You pay 50%

VISION

Caring for your vision is critical. An exam can detect if corrective lenses are needed so you can enjoy reading, watching TV, or working at your computer.

The vision plan is administered by **EyeMed** and Insight is the participating provider network.

- ☑ **$10 copay for an exam** (up to a $40 reimbursement for a non-Insight provider)
- ☑ **40% discount on glasses** (frames, lenses and 20% off on lens enhancements)
- ☑ **15% discount on laser correction**

The chart includes only a summary of in-network coverage—for more details, as well as out-of-network reimbursement options, refer to the carrier documents.

For additional discounts, create an account at eyemed.com, click on special offers to get your savings code.

ITEM/SERVICE	COVERAGE
Exam (every 12 months)	$10 copay
Glasses (every 12 months)	$15 copay
Frame (every 24 months)	$150 allowance 20% discount on remaining balance
Contacts (instead of glasses; every calendar year)	Up to $55 copay (fitting and evaluation) $150 allowance

FLEXIBLE SPENDING ACCOUNT (FSA)

SAU offers Flexible Spending Accounts through **iSolved Benefits**. Flexible Spending Accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. You select a dollar amount that is deducted pre-tax from your gross pay each pay period to fund your account.

SAU offers full-time employees three types of flexible spending accounts: Health Care Flexible Spending Account, Limited Medical Flexible Spending Account and Dependent Care Flexible Spending Account.

Here's how you save:

- The amount you contribute to a FSAs is deducted from your paycheck before Federal, State, local and Social Security taxes are withheld.
- When you have an eligible expense, you use money from (or are reimbursed from) your account(s) and the money isn't taxed.

Health Care FSA

The **Health Care FSA** allows you to pay for eligible expenses not already covered by a medical/prescription drug, dental or vision plan, such as co-pays and deductibles. You are not eligible for the Health Care FSA if you are enrolled in a high deductible health plan. You may contribute up to $2,750* to this account.

Limited Purpose FSA

If you enroll in the HMO medical plan, you are not eligible to elect the Health Care FSA. Rather, you can elect this account as it is compatible with High Deductible Health Plans. It allows you to set aside dollars to use for dental and vision expenses. You may contribute up to $2,750* to this account.

Dependent Care FSA

You can contribute up to $5,000 (a minimum of $100) to a Dependent Care FSA to pay for the day care of your dependent children under the age of 13 and dependents of any age who are incapable of self-care, who live with you at least eight hours per day, and who are claimed as dependents on your income tax return.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or overnight care, nursing home care, or for babysitting when you are not at work.

Note: If you contribute to a Dependent Care account, you must file an IRS form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Important!

The balances in your Health Care and Dependent Care FSAs are subject to "use it or lose it" rules. You should estimate your health and dependent care expenses *carefully* when deciding how much money to put in the Flexible Spending Accounts. The IRS requires that you forfeit any FSA amounts you do not use. Active employees will have until March 31, 2021 to submit expenses for the 2020 plan year. There is a $2.50 per month fee to open these accounts. SAU covers the remaining fees.

	Reimbursement Account Comparison			
	Health Savings Account	**Health Care FSA**	**Limited Purpose FSA**	**Dependent Care FSA**
Eligibility	Employees enrolled in a SAU medical plan	Employees not enrolled in a SAU medical plan.	Employees enrolled in a SAU medical plan	All employees who will have eligible dependent care expenses.
Tax-Advantaged	Yes	Yes	Yes	Yes
Balance Rollover	Yes	No	No	No
Earns Interest	Yes	No	No	No
Eligible Expenses	Medical, Prescription Drugs, Dental, and Vision	Medical, Prescription Drugs, Dental, and Vision	Dental and Vision	Dependent Care
Contribution Limit	Single: $3,600 Family: $7,200 Age 55+ Catch-Up: $1,000	$2,750	$2,750	$5,000
Investment Option	Yes	No	No	No

* Check with HR regarding the most updated IRS contribution limits.

LONG TERM DISABILITY

SAU provides a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. This coverage is provided free to employees and is administered by **Mutual of Omaha**.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. Review the certificate/benefit book for details on these and other important provisions.

Item	LTD Benefit
Monthly Benefit	60% of your monthly pre-disability earnings up to a maximum of $7,500 per month. Earnings are defined as gross monthly income in effect just prior to your date of disability, including pre-tax deductions. It does not include overtime pay, bonuses, commissions, other extra income or income received from sources other than your Employer. Your benefit may be reduced by deductible sources of income and disability earnings.
Elimination Period	You must be disabled 90 days during a 180 accumulation period. You must not be continuously disabled for the 90 day elimination period in order for you to be eligible for this benefit.
Benefit Period	If you become disabled prior to age 61, benefits are payable up to age 65, Social Security Normal Retirement age or 3 to 6 years, whichever is longest. Benefits are limited to 24 months in a person's lifetime for mental/nervous or substance abuse conditions.
Pre-existing Conditions	Benefits are not payable for a disability due to a pre-existing condition that begins within 12 months of your effective date of coverage. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medications during the 3 months prior to your effective date of coverage.

VOLUNTARY SHORT TERM DISABILITY

Our Short Term Disability (STD) plan pays you income if you are disabled from work due to a non-work related illness or injury. This is a voluntary option paid for by the employee and is administered by **Mutual of Omaha**.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. Review the certificate/benefit book for details on these and other important provisions.

Item	Benefit
Weekly Benefit	70% of your weekly pre-disability earnings up to $1,000 with a $25 minimum. Earnings are defined as base earnings not including commissions, overtime pay, bonuses, or any other special compensation not received as basic salary.
Elimination Period	21 days for disability due to an accident; or 21 days for disability due to an illness; Benefits begin the day after the elimination period is completed.
Benefit Period	Benefits are payable for up to 10 weeks.
Definition of Disability	You are disabled when Mutual of Omaha determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in weekly earnings due to the same sickness or injury. You must be under the regular care of a physician in order to be considered disabled.

GROUP LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

It is important to give serious consideration to what expenses and income needs your dependents would have if something happened to you. Life Insurance will pay your "beneficiary" a benefit in the event of your death. To ensure that all employees have a basic level of protection, SAU provides all eligible full-time employees with free basic life and AD&D insurance that is equal to one times your annual salary up to a maximum of $50,000. You are automatically enrolled if you are eligible.

Life benefits begin to reduce for employees age 65 and older. Please see the carrier certificate for details.

Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

According to the IRS regulations, the value of employer-provided group term life insurance over $50,000 is taxable income. This "additional taxable income" is subject to social security and Medicare taxes and must be reported on the employee's W-2 Form as "other compensation".

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

You have the opportunity to purchase additional life insurance for yourself, spouse and your children through post-tax payroll deductions. In order to purchase coverage for your spouse or children, you must first purchase Voluntary Coverage for yourself.

The amount of insurance on your dependent(s) will not exceed 50% of your election. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.

Please note: Employee and spouse coverage is reduced 35% at age 70, and 55% at age 75. Benefits will not be paid if the death results from suicide within 2 years after voluntary life insurance is effective. You must be actively at work on the effective date of your voluntary life coverage for your coverage to be effective. If you are not actively at work on that date, coverage will go into effect when you return to active work. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

Individual	Voluntary Coverage Amounts	Do You Need to Provide Medical Information (Evidence of Insurability)
Employee	Any multiple of $10,000; maximum of $500,000 or 7x annual earnings; minimum of $10,000	Yes, if you: • are electing in excess of $200,000; or • want to increase your coverage at future open enrollment periods; or • do not elect coverage when first eligible and later decide to elect coverage Coverage does not become effective until your request has been approved by United of Omaha Life Insurance Company.
Spouse	$5,000 minimum up to $250,000, not to exceed 100% of voluntary employee life coverage amount	Yes, if you: • are electing in excess of $50,000; or • do not elect coverage when first eligible and later decide to elect coverage Coverage does not become effective until your request has been approved by United of Omaha Life Insurance Company.
Child(ren)	$2,500 increments up to $10,000	No

Voluntary Life and AD&D continued.

Cost of coverage is based on your age and status of tobacco use. The cost for your spousal voluntary life election is based on the employees age.

EMPLOYEE PREMIUM TABLE FOR NON-TOBACCO USERS (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
30 - 34	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
35 - 39	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40 - 44	$1.05	$2.10	$3.15	$4.20	$5.25	$6.30	$7.35	$8.40	$9.45	$10.50
45 - 49	$1.75	$3.50	$5.25	$7.00	$8.75	$10.50	$12.25	$14.00	$15.75	$17.50
50 - 54	$2.90	$5.80	$8.70	$11.60	$14.50	$17.40	$20.30	$23.20	$26.10	$29.00
55 - 59	$5.00	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00	$45.00	$50.00
60 - 64	$6.90	$13.80	$20.70	$27.60	$34.50	$41.40	$48.30	$55.20	$62.10	$69.00
65 - 69	$10.50	$21.00	$31.50	$42.00	$52.50	$63.00	$73.50	$84.00	$94.50	$105.00
70+	$22.00	$44.00	$66.00	$88.00	$110.00	$132.00	$154.00	$176.00	$198.00	$220.00

EMPLOYEE PREMIUM TABLE FOR TOBACCO USERS (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50
30 - 34	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
35 - 39	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00
40 - 44	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25	$22.50
45 - 49	$3.70	$7.40	$11.10	$14.80	$18.50	$22.20	$25.90	$29.60	$33.30	$37.00
50 - 54	$6.10	$12.20	$18.30	$24.40	$30.50	$36.60	$42.70	$48.80	$54.90	$61.00
55 - 59	$9.40	$18.80	$28.20	$37.60	$47.00	$56.40	$65.80	$75.20	$84.60	$94.00
60 - 64	$10.60	$21.20	$31.80	$42.40	$53.00	$63.60	$74.20	$84.80	$95.40	$106.00
65 - 69	$14.40	$28.80	$43.20	$57.60	$72.00	$86.40	$100.80	$115.20	$129.60	$144.00
70+	$26.00	$52.00	$78.00	$104.00	$130.00	$156.00	$182.00	$208.00	$234.00	$260.00

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.25	$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50
30 - 34	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
35 - 39	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
40 - 44	$0.53	$1.05	$1.58	$2.10	$2.63	$3.15	$3.68	$4.20	$4.73	$5.25
45 - 49	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75
50 - 54	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
55 - 59	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$25.00
60 - 64	$3.45	$6.90	$10.35	$13.80	$17.25	$20.70	$24.15	$27.60	$31.05	$34.50
65 - 69	$5.25	$10.50	$15.75	$21.00	$26.25	$31.50	$36.75	$42.00	$47.25	$52.50

ALL CHILDREN PREMIUM TABLE			
(12 PAYROLL DEDUCTIONS PER YEAR)			
$2,500	**$5,000**	**$7,500**	**$10,000**
$0.44	$0.87	$1.31	$1.74

VOLUNTARY INSURANCE

Sometimes, the unexpected occurs. Voluntary worksite coverage are affordable ways to protect yourself financially from unforeseen medical emergencies. These products are administered by Aflac and are paid for through post-tax payroll deductions. Each of these products can be purchased independent of the other, and of other SAU benefits. They are all portable in the event you leave SAU. Pre-existing conditions may apply. Please review the full benefit details.

We know how important it is for you to receive you preventive care services, so these plans each include a Wellness Benefit (chest x-ray, colonoscopy, mammography, Pap smear, etc.).

Aflac Cancer Care

When faced with cancer, the cost of treatments can add up very quickly! This coverage allows you to receive a lump sum payment to help cover those costs. Whether it is chemotherapy or a second surgical opinion, simply make a claim to Aflac. Coverage can be purchased for you, your spouse and your children.

Aflac Accident Insurance

Aflac's voluntary accident insurance gives you something to help when accidental injuries occur. This coverage can help employees meet out-of-pocket expenses (e.g. deductibles and coinsurance and other extra bills). You have coverage on and off the job for a wide variety of injuries and accidents such as home falls and kid's sports injuries. Benefits are paid directly to the team member. There are no limits on the number of accidents the policy covers and rates do not increase as you age. If you take coverage yourself, you can cover other family members as well.

Aflac Hospital Choice

Hospital Choice coverage is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Hospital Choice lump sum benefits are paid directly to you based on the amount of coverage listed on the schedule of benefits, regardless of the actual cost of treatment. Coverage is available for you, your spouse and your children providing you elect coverage for yourself.

Aflac Plus Rider—Critical Illness

This coverage is designed to help employees offset the financial effects of a catastrophic illness. Benefits are based on the amount of coverage in effect on the date of a diagnosis for such illnesses as heart attack, stroke or coma. The benefit can be used however you choose, for the expenses your health insurance doesn't cover. You can keep this coverage even if you change employers and full benefits are available to all family members.

403B RETIREMENT PLAN

Employees may begin to contribute at the time of hire or any time after. SAU will contribute 5% of an employees gross wages after you have one year of service with SAU. New employees with a current TIAA account and can provide proof of such, SAU will begin to contribute at time of hire. At age 55 and above or 10 years of service, SAU will contribute 6%.

ADDITIONAL SAU BENEFITS

Employees may be eligible for the following additional benefits. See the SAU Employee Manual for details on eligibility (located on SAU portal).

- Paid time off
- Sick Leave
- Jury Duty
- Bereavement Leave
- Holidays
- FMLA Leave
- Moving Expense Reimbursement
- Dining Commons Discount
- Tuition Discount
- Bookstore Discount
- Use of Fieldhouse & fitness room
- Admission to Athletic Events

HEALTH ADVOCATE

The bill from your doctor can be both mysterious and frustrating. Do you really owe that much? Does there seem to be a mistake in what you're being charged? And if the bill is correct, is the amount so high that you will struggle to pay it?

Health Advocate can assist you with all this and more! A team of health care professionals, who are experts in navigating the insurance and health care systems, are on your side. These skilled advocates can save you both time and money as they contact your providers to resolve issues and negotiate payment plans.

Health Advocate can also help you to better understand the care you are receiving. Do you feel like your doctor doesn't take enough time with you? Call Health Advocate if you have questions about your tests or medications, or to help coordinate care with different health care providers.

Personal Health Advocates are available to help you on a number of healthcare related items including:

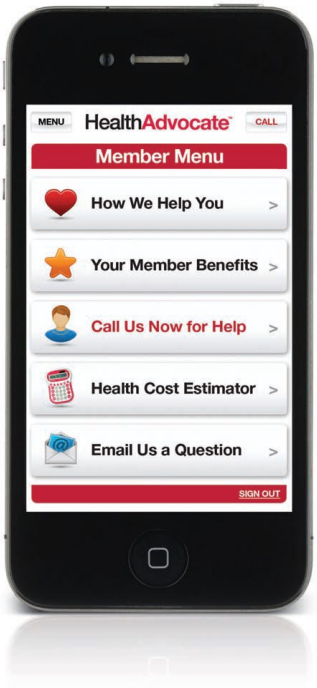
- Untangling medical bills and insurance claims
- Understanding test results, treatments and medications
- Locating services for elderly parents
- Securing second opinions
- Transfering medical records
- Using the Health Cost Estimator

All benefit enrolled employees, their spouses, children, parents and parents -in-law are eligible for Health Advocate assistance.

A Personal Health Advocate is available to help you today.

Call 866-695-8622 or email answers@HealthAdvocate.com

On-the-go help from the convenience of your phone is also available. Download the free mobile application today from the App Store or Google Play.



CONTACT

CARRIER	PHONE	WEBSITE
Blue Care Network (BCN) Medical	(800) 662-6667	www.bcbsm.com
BASIC HRA	(888) 472-0777	https://basiconline.com
Express Scripts Prescription Drugs	(800) 229-0832	www.express-scripts.com
Walgreens Pharmacy Specialty Prescription Drugs	(866) 515-1355	www.Walgreens.com/pharmacy www.alliancerxwp.com
Teladoc 24/7 doctor visits	(800) Teladoc (835-2362)	www.teladoc.com
Delta Dental of Michigan Dental Dental	(800) 524-0149	www.deltadentalmi.com
EyeMed Vision (Insight network)	(866) 723-0513	www.eyemed.com
Mutual of Omaha Life, AD&D and Disability	(800) 877-5176	www.mutualofomaha.com
isolved Benefit Services Flexible Spending Accounts (FSA)	(800) 300-3838	www.isolvedbenefitservices.com
County National Bank Health Savings Account (HSA)	(888) 322-1088 (517) 439-4300	www.countynationalbank.com
Aflac Accident, Hospital Choice, Accident, Cancer	(269) 998-9950 E-mail: Chris_bouldrey@us.aflac.com	
Health Advocate Advocacy	(866) 695-8622	www.healthadvocate.com
Human Resources General inquires	x1576 E-mail: SpringArbor.HR@arbor.edu	The Portal

LEGAL NOTICES

Patient Protection and Affordable Care Act ("Health Care Reform")

Patient Protection

Blue Care Network (BCN) generally requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. Until you make this designation, **BCN** designates one for you. For information on how to select a PCP, and for a list of the PCP providers, contact **BCN at bcbsm.com or (800) 662-6667**.

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

You do not need prior authorization from **BCN** or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact **BCN at bcbsm.com or (800) 662-6667.**

Other Important Information

Midyear Election Changes to Pre-Tax Benefits

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the

next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

HIPAA Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Marketplace coverage) or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Summary of Material Modification

The information in this document and in the benefit guide applies to the **Spring Arbor University Plan, No. 508**. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the **Benefit Guide,** the Benefit Plan Notice Requirements document, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. **Spring Arbor University** reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a post-secondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

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

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

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

CALIFORNIA – MEDICAID
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-916-440-5676

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

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

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

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

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

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

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

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

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

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

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

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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

To see if any other states have added a premium assistance program since July 31, 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
  1-866-444-EBSA (3272)
- U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, www.cms.hhs.gov
  1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice from Spring Arbor University About Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Spring Arbor 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. **Spring Arbor University has determined that the prescription drug coverage offered by the Spring Arbor University 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 through 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.

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 Spring Arbor University coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Spring Arbor University coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 Spring Arbor 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 **Spring Arbor 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
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	October 2020
Name of Entity/Sender:	Spring Arbor University
Contact--Position/Office	Human Resources
Address:	106 E. Main St.
Phone Number:	517-750-6575

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

Now that key parts of the health care law have taken effect, there is 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. For 2021, open enrollment for health insurance coverage through the Marketplace begins November 1, 2020 and ends December 15, 2020, for coverage starting January 1, 2021.

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 9.86% of your household income for 2021, 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.

If you work full-time and are eligible for coverage under your employer's health plan, the plan satisfies the minimum value standard, and the cost is intended to be affordable based on employee wages.

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 your Human Resource department at 517-750-1428.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. 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] A health plan provides "minimum value" if the plan's share of the total allowed benefit costs covered by the plan is at least 60% of such costs.