2024 BENEFITS GUIDE

Spring Arbor UNIVERSITY

Your Health & Wellness

CONTENTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

The information in this Enrollment Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage, and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any expressed or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact Human Resources. **SAU reserves the right to amend, modify or terminate any plan at any time and in any manner.**

WELCOME TO YOUR 2024 BENEFITS!

Spring Arbor University is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefit guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

ELIGIBILITY

If you are regularly scheduled to work at least 30 hours per week or an equivalent teaching load for full-time status classification, you are eligible for the Spring Arbor University benefits program. For newly hired individuals, most of your benefits are effective the first day of the month following your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents include:

- Your legal spouse. A legal spouse is a person of the opposite biological sex to whom you are married at the relevant time by a religious or civil ceremony under the laws of the state in which the marriage was contracted.
- Your children (including your adopted, biological, and step-children) up to the end of the month in which they turn 26
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

For details on eligibility and when your benefits begin and end, refer to your summary plan documents.

Benefits End

Your SAU benefits will end when you are reclassified to an ineligible status, or you stop paying your share of the premium. Your medical, dental and vision benefits end the last day of the month in which you become ineligible. Your company-sponsored life and disability benefits end on the date you become ineligible.

Qualifying Life Event

During the year, you **cannot** make changes to your medical, dental, vision, or Health Care or Dependent Care Flexible Spending Accounts **unless** you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you should contact Human Resources within **30 days of the event**, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

HOW TO ENROLL

If you are a new hire, you have 14 days to enroll from your date of hire. You must complete your enrollment to receive benefit coverage for the plan year.

Before You Enroll

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Log in (if you have an account) or Register (new users) at www.paycor.com (see instructions below).
- Be sure to complete beneficiary information for Life and AD&D benefits.
- Select, review and submit your desired coverage.
- Questions? Contact Human Resources at SpringArbor.HR@arbor.edu or 517-750-6575.

BenAdvisor Enrollment Instructions

- Please use the Paycor link www.paycor.com or visit the SAU portal and click on the Paycor icon, located on the homepage.
  - Once in Paycor, click on the 3 horizontal lines on the top left (the hamburger)
  - Next Click People > Benefits, and then click Benefits Advisor
  - You will be directed to your Benefits Home screen, click on Start Your Enrollment
- If you forget your username, please contact Human Resources.
- If you forget your password, please use the "forgot password" link within Paycor or contact Human Resources at SpringArbor.HR@arbor.edu or 517-750-6575.

MEDICAL

GuideStone

SAU's medical coverage, through Guidestone, provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
  - **Aggregate** — The total family deductible must be met before insurance starts paying for services incurred by any family member (no embedded deductible for each individual family member to meet). The plans that have an aggregate deductible are the Health Saver 2000 and the Health Saver 2800.
  - **Embedded** — A single member of your family doesn't have to meet the full family deductible for coinsurance to kick in. Once one person meets the single deductible amount, their coinsurance will begin. The plans that have an embedded deductible are the Health Saver 4000 and the Health Choice 1000.
- **Copays** — a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses. The option that has the highest per-pay-period cost typically pays more, which results in lower deductibles, coinsurance, and/or copays when you need care.
2. Ensure your doctor is in the plan's network by visiting GuideStoneHealth.org and select **My Plan**. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.
4. Evaluate how your out-of-pocket expenses may fluctuate and consider adding one of our Voluntary Aflac plans listed on page 21 to help offset your out-of-pocket medical costs.

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

	Health Saver 2000	Health Saver 2800	Health Saver 4000	Health Choice 1000
	HSA-qualified HDHP[1]	HSA-qualified HDHP[1]	HSA-qualified HDHP[1]	Not eligible for HSA
	In-Network	In-Network	In-Network	In-Network
Deductible	Aggregate	Aggregate	Embedded	Embedded
Individual	$2,000	$2,800	$4,000	$1,000
Family	$4,000	$5,600	$8,000	$2,000
Out-of-Pocket Maximum (Includes Deductible)				
Individual	$4,000	$4,900	$6,000	$5,000
Family	$7,500	$7,500/$9,800 individual/family	$12,000	$8,250
	You pay	You pay	You pay	You pay
Coinsurance	10% after deductible	20% after deductible	20% after deductible	20%
Preventive Care	0% no deductible	0% no deductible	0% no deductible	$0
Teladoc	0% coinsurance	0% coinsurance	0% coinsurance	$0
Primary Care Physician	10% after deductible	20% after deductible	20% after deductible	$25
Specialist	10% after deductible	20% after deductible	20% after deductible	$45
Urgent Care	10% after deductible	20% after deductible	20% after deductible	$50
Emergency Room	After deductible, $250 copay then 10%	After deductible, $250 copay then 20%	After deductible, $250 copay then 20%	$250 copay, then 20%
Lab & X-ray	10% after deductible	20% after deductible	20% after deductible	20% (deductible may apply)
Hospitalization	10% after deductible	20% after deductible	20% after deductible	20% (deductible may apply)
Diagnostic Imaging (MRI/CT)	10% after deductible	20% after deductible	20% after deductible	20% (deductible may apply)
Pharmacy				
Retail Rx (up to 30-day supply)				
Generic	10% after deductible	20% after deductible	20% after deductible	$15[2]
Preferred	10% after deductible	20% after deductible	20% after deductible	$50[2]
Non-preferred	10% after deductible	20% after deductible	20% after deductible	$75[2]
Mail Order Rx (90-day supply)				
Generic	10% after deductible	20% after deductible	20% after deductible	$30
Preferred	10% after deductible	20% after deductible	20% after deductible	$100
Non-preferred	10% after deductible	20% after deductible	20% after deductible	$150
Specialty (up to 30-day supply)				
Generic	10% after deductible	20% after deductible	20% after deductible	$50
Preferred	10% after deductible	20% after deductible	20% after deductible	$75
Non-preferred	10% after deductible	20% after deductible	20% after deductible	$100

[1]You can contribute to a full Health Care FSA if you are ineligible to make contributions to an HSA.

[2]Using a Non-Walgreens retail pharmacy may result in a $10 penalty

MEDICAL

Teladoc

Guidestone medical plans include coverage for telemedicine services such as General Medical, Dermatology and Mental Health. Physicians can diagnose, treat and prescribe medication when medically necessary for a wide range of conditions.

General Medical	Dermatology	Mental Health (Licensed Therapist)
24/7 access to U.S board-certified physicians who are available anytime, anywhere and can resolve many non-emergency medical issues.	Simply upload images of a skin issue online or on the app and get a custom treatment plan within two days.	Talk to a therapist or psychiatrist seven days a week (7 a.m. to 9 p.m. local time) from wherever you are.
Conditions may include: • Bronchitis • Flu • Rashes • Sinus infections • Sore throats	Conditions may include: • Acne • Eczema • Raised moles • Rashes • Rosacea	Conditions may include: • Anxiety • Depression • Not feeling like yourself • Marital issues • Stress
Health Saver 2000, 2800 and 4000: • 0% coinsurance Health Choice 1000: • $0 co-pay	Health Saver 2000, 2800 and 4000: • 0% coinsurance Health Choice 1000: • $0 co-pay	Health Saver 2000, 2800 and 4000: • 0% coinsurance Health Choice 1000: • $0 co-pay

Visit Teladoc.com/GuideStone or Guidestone.org/WellnessTools to register.

MEDICAL

Medical Monthly Payroll Deductions				
	Health Saver 2000	Health Saver 2800	Health Saver 4000	Health Choice 1000
Employee Only	$130.26	$56.16	$51.86	$174.16
Employee + Spouse	$303.50	$130.88	$120.84	$405.78
Employee + Child(ren)	$260.52	$112.34	$103.70	$348.34
Employee + Family	$377.76	$162.90	$150.36	$505.08

Michigan No Fault Auto

When you are in a car accident be aware that:

- The Spring Arbor University and Guidestone Medical Plans cover automobile-related medical claims as secondary.
    - This applies whether or not you have no-fault automobile coverage.
- When an automobile-related claim is submitted to Highmark BCBS, through Guidestone, it will reject, and you will need to make sure it is submitted to your automobile insurance carrier first.
- Should you need a qualified health coverage letter (QHC), contact a Quantum Health Care Coordinator, through Guidestone, at 855-497-1230.

PRESCRIPTION PROGRAMS

EXPRESS SCRIPTS®

Guidestone's prescription drug plans include different drug management programs.

Prior Authorization

Certain clinical criteria must be met before coverage is provided for select drugs

Step Therapy

Requires previous treatment with one or more drugs on the formulary before coverage is approved

Non-Generic

If a non-generic drug is purchased when a generic is available, you will pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

Maintenance Medications

Maintenance medications are those you take regularly for ongoing conditions.

- A 90-day supply of maintenance medications can be filled at a retail Walgreens location or via home delivery through Express Scripts.
- Select diabetic products may be available for a $75 co-pay for a 90-day supply.
- For additional information about the Express Scripts mail-order program, refer to GuideStone.org/HomeDelivery or call 800-555-3432 to speak with an Express Scripts patient care advocate.

Home Delivery

Make the switch to mail-order for your maintenance medications and save one month's copayment!

You have three options for transferring your prescriptions to mail order:

1. **ePrescribe**
   - Ask your doctor to send your prescription electronically to the Express Scripts Pharmacy.
2. **Call Express Scripts at 800-555-3432.**
   - Speak with a prescription plan specialist Monday through Friday between 7:30 a.m. and 5 p.m. ET.
3. **Complete a Home Delivery Order Form**
   - Get a 90-day prescription plus refills for up to one year (if applicable).
   - Include your home delivery co-payment.
   - Mail your form, payment (or payment information) and prescription to the address on the form.

- Visit www.express-scripts.com/pharmacy/how-it-works to learn more.
- Find eligible medications at www.guidestone.org/-/media/Insurance/pdf/MaintenanceMedications.

HEALTH SAVINGS ACCOUNT (HSA)

County National Bank
Banking that stays in the community

A Health Savings Account (HSA) is a personal savings account that you own and can use to pay for qualified out-of-pocket medical expenses. SAU has partnered with County National Bank to administer your HSA. Contributions taken out of your paycheck are tax-free. Once you enroll in the HSA, you'll receive a debit card to pay for qualified out-of-pocket medical expenses. Your HSA can be used to pay for your health care expenses and those of your spouse and dependents, even if they are not covered by the High Deductible Health Plan (HDHP).

How a Health Savings Account (HSA) Works

Eligibility
Anyone who is:
- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not a High Deducible Health Plan (HDHP);
- Not entitled to Medicare benefits;
- Not eligible to be claimed on another person's tax return;
- Not in receipt of VA benefits within the last 3 months; or
- Not covered under your or your spouse's Flexible Spending Accounts (FSAs), except for a Limited Purpose FSA

Your Contributions
- You choose how much to contribute from each paycheck on a pre-tax basis.
- You can contribute up to the 2024 IRS maximum of **$4,150/individual** or **$8,300/family**. Please contact HR to make any changes to your HSA contribution amount throughout the plan year.
- You can make an additional "catch-up" contribution of up to $1,000 per year if you are age 55 or older.

Eligible Expenses
- You can use your HSA to pay for medical, dental, vision, and prescription drug expenses incurred by you and your eligible family members. **SAVE YOUR RECEIPTS!!!**
- Eligible or "qualified" expenses are defined by Section 213(d) of the IRS Tax Code. Visit irs.gov and search Publication 502 or view and purchase eligible expenses right from this site hsastore.com.
- *Please note: Funds available for reimbursement are limited to the balance in your HSA.*

Using Your Account
- Use the debit card linked to your HSA to cover eligible expenses — or pay for expenses out of your own pocket and save your HSA dollars for future health care expenses.

Your HSA is always yours – no matter what
- One of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it the following year or at any time in the future.
- And if you leave the SAU or retire, your HSA goes with you.

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.

The Triple Tax Advantage

HSAs offer three significant tax advantages:

1. You can use your HSA funds to cover qualified medical expenses, including dental and vision expenses — tax-free.
2. Unused funds grow and can earn interest over time — tax-free.
3. You can save your HSA dollars to use for your health care when you leave SAU or retire — tax-free.

If you want to pay less per paycheck for health care coverage and save tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Year 1 Example: You enroll in the HDHP with HSA during enrollment		Year 2 Example: You enroll in the HDHP plan again next year
You contribute $3,600 for a total of $3,600		$2,900 rolls over from last year and you contribute $3,600 for a total of $6,500
You use the HSA to pay $700 of eligible expenses		You use the HSA to pay $1,250 of eligible expenses
You have $2,900 in the HSA to roll over to next year!		**You have $5,250 in the HSA to roll over to next year!**

DENTAL

DELTA DENTAL®

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures. Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

SAU offers dental coverage through Delta Dental. For information on finding a dental provider using the PPO network, visit www.deltadentalmi.com and click on Find a Dentist.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates (claim example shown below).

Example savings for a crown by network	Submitted charge	Maximum allowed fee	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Total network savings
Delta Dental PPO	$950	$675	50%	$337.50	$0	$337.50	$275
Delta Dental Premier	$950	$898	50%	$449	$0	$449	$52
Out-of-network	$950	$744	50%	$372	$206	$578	$0

The table below summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Dental Plan	
	Delta Dental	
	PPO Dentist	Out-of-Network[1]
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year Benefit Maximum		
Per Individual	$1,000	$1,000
	You pay	
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments, Sealants, Space Maintainers	100%	100%[1]
Basic Services		
Fillings, Crown Repairs, Oral Surgery, Endodontics, Periodontics	80%	80%[1]
Major Services		
Bridges, Implants, Dentures, Crowns over implants	50%	50%[1]
Orthodontia (to age 19)		
Orthodontia Lifetime Maximum	$1,000	$1,000
Braces	50%	50%[1]
Dental Monthly Payroll Deductions		
Employee Only	$40.28	
Employee + 1	$75.90	
Employee + Family	$150.68	

[1]When you receive services from a non-participating Dentist, the reimbursement amount **may be less** than what the Dentist charges or Delta Dental approves, and you are responsible for that difference.

VISION

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents — or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect a vision plan.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

SAU offers vision coverage through EyeMed using the Insight network. For information on finding a vision provider, visit www.eyemed.com and click on Find an Eye Doctor.

	EyeMed Insight Network	
	In-Network	Out-of-Network
	You pay	Reimbursement
Cost		
Exam	$10 copay	Up to $40
Covered Services – Lenses		
Single Lenses	$25 copay	Up to $30
Bifocals	$25 copay	Up to $50
Trifocals	$25 copay	Up to $70
Frames	Up to $150 allowance; 20% off balance over $150	Up to $105
Covered Services – Contacts in lieu of Frames/Lenses		
Contacts – Medically Necessary	$0 copay, paid-in-full	Up to $210
Contacts – Elective	Up to $150 allowance	Up to $150
Benefit Frequency		
Exams	Once every 12 Months	
Lenses / Contacts (in lieu of lenses)	Once every 12 Months	
Frames	Once every 24 Months	
Vision Monthly Payroll Deductions		
Employee Only	$6.76	
Employee + 1	$12.83	
Employee + Family	$18.84	

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. SAU has partnered with isolved Benefit Services to administer these accounts. There are three types of FSAs — the Health Care FSA, the Limited Purpose Health Care FSA and the Dependent Care FSA:

- **Health Care FSA** – Used to pay for out-of-pocket expenses associated with your medical, dental or vision plan such as copayments, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- **Limited Purpose Health Care FSA** – Used if you are enrolled in the **HDHP** medical plan. It works the same way as the standard Health Care FSA; however, you may only use it to pay for eligible vision and dental expenses.
- Visit irs.gov and search Publication 502 or view and purchase eligible expenses right from this site fsastore.com.
- **Dependent Care FSA** – Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

You cannot use your Health Care FSA to pay for dependent care expenses, and you cannot use your dependent care FSA to pay for health care expenses.

Important: The IRS has a "use it or lose it" rule. If you do not spend all of the money in your FSA by the annual deadline, any unused dollars in your account(s) will be forfeited. There is a $2.50 per month fee to have an FSA account. SAU will cover the remaining fees.

	Health Care FSA	Limited Purpose FSA	Dependent Care FSA
Eligibility	Employees enrolled in the **Health Choice PPO** or those **ineligible** to make contributions to an HSA.	Employees enrolled in a SAU **Health Saver HDHP** plan	All employees who will have eligible dependent care expenses.
Tax-Advantaged	Yes	Yes	Yes
Balance Rollover	No	No	No
Earns Interest	No	No	No
Eligible Expenses	Medical, Prescription Drugs, Dental, and Vision	Dental and Vision	Dependent Care
Contribution Limit	$3,050	$3,050	$5,000
Investment Option	No	No	No

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

Life insurance, administered by Mutual of Omaha (MOO), pays a lump-sum benefit to your beneficiaries to help meet expenses in the event you pass away. AD&D insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (such as loss of sight or the loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Beneficiary Information

Situations often change, resulting in the need to update beneficiary information. You should review and update this information every year, or prior to retirement. Please review Paycor to ensure your information is up to date.

Life / AD&D Insurance - For You	
	Life and AD&D
Coverage Amount	1x base annual earnings up to $50,000, rounded to next higher multiple of $1,000
Evidence of Insurability / Proof of Good Health	Not required
Age Reduction Schedule	Benefits reduce by 65% at age 65 and 50% at age 70.

Employee Assistance Program

You also have access to the Employee Assistance Program (EAP) at no cost to you. This program, available through MOO, directs you to online resources focusing on topics such as:

- Emotional Well-Being
- Family and Relationships
- Legal and Financial
- Healthy Lifestyles
- Work and Life Transitions

MOO will also provide a list of in-network providers should you want to seek counseling.

Visit mutualofomaha.com/eap or call 800-316-2796 to learn more.

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

Mutual of Omaha

Voluntary life and AD&D insurance allow you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death or accidental serious injury. Voluntary life insurance for you and your dependents, also administered by MOO, can help protect your family during difficult times.

Life / AD&D Insurance - For You and Your Dependents			
	Employee	Spouse	Child(ren)
Coverage Amount	Increments of $10,000 up to $500,000 - not to exceed 7 times your salary	Increments of $5,000 up to $250,000 – not to exceed 100% of Employee coverage	Increments of $2,500 to a maximum of $10,000 – not to exceed 100% of Employee coverage
Guaranteed Issue	$200,000	$50,000	N/A
Evidence of Insurability/ Proof of Good Health	Required if electing coverage over the Guaranteed Issue amount or electing coverage for the first time		Not required
Age Reduction Schedule	Benefits reduce by 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85 and 15% at age 90.		

Guaranteed Issue (GI) and Evidence of Insurability (EOI)

Employees and spouses who elect coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). Any coverage increase over the GI amount or elected after your new hire enrollment window, requires an EOI form for medical underwriting approval.

Before You Enroll

Consider this:

1. Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
2. It's important to understand any EOI rules that apply. If you enroll when you first become eligible, Voluntary Term Life Insurance for you and your spouse is guaranteed up to the amounts shown in the table. If you initially waive this coverage but want to enroll at a later date, you may need to provide satisfactory EOI before any coverage can take effect.
3. Think about who you want to designate as beneficiaries and make sure to name them as beneficiaries on your policy.

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

Mutual of Omaha

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 Monthly Premium Table (Non-Tobacco)										
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 Monthly Premium Table (Tobacco)										
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 Monthly Premium Table										
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

Children Monthly Premium Table			
$2,500	$5,000	$7,500	$10,000
$0.44	$0.87	$1.31	$1.74

DISABILITY

Mutual of Omaha

Disability insurance can help you remain financially stable by providing a portion of your income if you are disabled from work due to a non-work related illness or injury.

Our Short-Term Disability (STD) plan is a **voluntary** option paid for by employees and is administered by Mutual of Omaha (MOO).

Voluntary STD Benefits at a Glance	
Weekly Benefit	70% of weekly earnings
Weekly Maximum	$1,000 per week
Benefit Duration	10 weeks
Elimination Period	21 days
Pre-Existing Limitation	3/6*
Benefits may not be paid for any condition treated within **three months prior to your effective date until you have been covered under this plan for **six months**.*	

MOO considers the total of all your income from other sources of income in determining the amount of your Weekly Benefit.

Examples of other sources of income that **may reduce** your total weekly benefit are:

- Contract/employment memos for non-twelve-month staff and faculty members
- An individual disability policy or disability coverage through your auto carrier
- Social Security

Please review the STD certificate for full plan details and exclusions

SAU provides a Long-Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. Benefits are provided at no cost through MOO. You are automatically covered as a full-time employee – no enrollment is needed.

Employer Paid LTD Benefits at a Glance	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$7,500 per month
Benefit Duration	To age 65 or SSNRA
Elimination Period	90 days
Pre-Existing Limitation	3/12*
Benefits may not be paid for any condition treated within **three months prior to your effective date until you have been covered under this plan for **twelve months**.*	

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within three months of the effective date of your insurance plan.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

SUPPLEMENTAL BENEFITS

Sometimes, the unexpected occurs. Purchasing supplemental worksite coverage is an affordable way to protect yourself financially from unforeseen medical emergencies. These products are administered by Aflac and are paid for through pre- or post-tax payroll deductions depending on the coverage option you choose. Each of these products can be purchased independent of the other. They are all portable in the event you leave SAU. Pre-existing conditions may apply.

Remember, each plan includes a Wellness Benefit for preventive services such as a chest x-ray, colonoscopy, mammography, pap smear and more. Please review the full benefit details by visiting https://express.adobe.com/page/2rr0gKVXS9ehY.

Cancer Protection Assurance

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. If you take coverage yourself, you can cover other family members as well. Plans offer a $25, $40 or $75 annual wellness benefit.

Accident Advantage

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. 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. Plans offer a $60 annual wellness benefit.

Hospital Choice

Hospital Choice coverage is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. You can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. 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. If you take coverage yourself, you can cover other family members as well.

Critical Illness Plus Rider

This coverage is designed to help you 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.

PLANNING FOR RETIREMENT

What does retirement look like for you? Whatever your vision for retirement is, it's important to plan ahead so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 403(b) savings plan, administered through TIAA, allows you to do just that. You can begin contributing to the plan through payroll deductions as soon as you become eligible.

Increase Your Retirement Savings with a 403(b)

- Employees may begin to contribute at the time of hire or any time after.
- SAU will contribute 5% of a benefit eligible employee's gross wages after you have one year of service with SAU (employee contributions are not required).
- At age 55 and above or 10 years of service, SAU will contribute 6% for benefit eligible employees (employee contributions are not required).
- Newly benefit eligible employees with a current TIAA account and can provide proof of such, SAU will begin to contribute at time of hire.
- To schedule a consultation, call 800-842-2776 or visit www.tiaa.org/schedulenow.

ADDITIONAL BENEFITS

SAU Exclusives

Employees may be eligible for the following additional benefits. See the SAU Employee Manual, posted within the HR pages of the SAU portal, for details on eligibility.

- 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 and Fitness Room
- Admission to Athletic Events

LifeMart

Make everyday life more affordable with LifeMart. Get exclusive offers on childcare, travel, nutrition services, and more through the members-only online discount program.

Access savings on major brands to everyday essentials—from car rentals to computers, groceries to gifts, electronics to entertainment and so much more. Available FREE to SAU employees. Visit https://discountmember.lifecare.com/registration/register1.rtml?banner=9281483/JITIG7ZW29V10rOReeAUt0A+StA= or scan the QR code below to register.

IMPORTANT CONTACTS

Coverage	Phone / Email	Website
Guidestone (Highmark BCBS) Medical & Quantum Health Member Services	855-497-1230	www.guidestonehealth.org
Teladoc Telemedicine	800-835-2362	www.teladoc.com/guidestone
Express Scripts Prescription Drug Member Services	800-555-3432	www.express-scripts.com
County National Bank Health Savings Account (HSA)	888-322-1088 / 517-439-4300	www.countynationalbank.com
Delta Dental Dental	800-524-0149	www.deltadentalmi.com
EyeMed (Insight Network) Vision	866-723-0513	www.eyemed.com
isolved Benefit Services Flexible Spending Accounts (FSAs)	800-300-3838	www.isolvedbenefitservices.com
Mutual of Omaha Life, AD&D and Disability	800-877-5176	www.mutualofomaha.com
Mutual of Omaha Employee Assistance Program	800-316-2796	www.mutualofomaha.com/eap
Aflac Cancer Care, Accident, Hospital Choice, Critical Illness	269-998-9950 Chris_bouldrey@us.aflac.com	https://express.adobe.com/page/2rr0gKVXS9ehY
TIAA 403(b) Retirement	800-842-2776	www.tiaa.org/public/tcm/springarboruniversity
Human Resources General Inquiries	x1575 SpringArbor.HR@arbor.edu	SAU Portal

GLOSSARY

Aggregate Deductible: The total family deductible must be met before insurance starts paying for services incurred by any family member (no embedded deductible for each individual family member to meet). The plans that have an aggregate deductible are the Health Saver 2000 and the Health Saver 2800.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference (see Balance Billing).

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you’ve paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you’ve paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Embedded Deductible: A single member of your family doesn't have to meet the full family deductible for coinsurance to kick in. Once one person meets the single deductible amount, their coinsurance will begin. The plans that have an embedded deductible are the Health Saver 4000 the Health Choice 1000.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount you will have to complete an Evidence of Insurability (EOI) form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don’t contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn’t include your monthly premiums. It also doesn’t include anything you may spend for services your plan doesn’t cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

LEGAL NOTICES

Spring Arbor University
Health and Welfare Benefits Notice

For Plan Year January 1, 2024 – December 31, 2024

Enclosed Notices:

- Summary of Material Modifications
- Disclosure About the Benefit Enrollment Communications
- Midyear Election Changes to Pre-Tax Benefits
- HIPAA Special Enrollment Rights Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' And Mothers' Health Protection Act (NMHPA) Notice
- Medicaid and the Children's Health Insurance Program (CHIP)
- Your Prescription Drug Coverage and Medicare
- HIPAA Notice of Availability of Notice of Privacy Practices
- New Health Insurance Marketplace Coverage Options and Your Health Coverage

Should you have any questions regarding the content of the notices, please contact us at Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

Summary of Material Modification

The information in this document and in the benefit guide applies to the Spring Arbor University Health and Welfare Plan, Plan Number 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 Health and Welfare Benefits Notices, 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.

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at Customer Service number on your member identification card.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

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

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, 2023. Contact your State for more information on eligibility:

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

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

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

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

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 and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-867-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program
(KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.com
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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102
Email: masspremassistance@accenture.com

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: 1-573-751-2005

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid
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/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

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:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2023, 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. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov/
Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

Medicare Part D Creditable Coverage Notice

Important Notice from Spring Arbor 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 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 Guidestone 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.

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

If you decide to join a Medicare drug plan while enrolled in Spring Arbor University coverage as an active employee, please note that your Spring Arbor University coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Spring Arbor University coverage as a former employee.

You may also choose to drop your Spring Arbor University coverage. 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.

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 2023
Name of Entity/Sender:	Spring Arbor University
Contact--Position/Office	Human Resources
Address:	106 E Main St, Spring Arbor, MI 49283
Phone Number:	517-750-6575

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Spring Arbor University sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Spring Arbor University, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;

(2) the provision of health care to you; or

(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Spring Arbor University, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact:

Spring Arbor University
Attention: HIPAA Privacy Officer

106 E Main St,
Spring Arbor, MI 49283
517-750-6575

Effective Date

This Notice as revised is effective October 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. 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. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

in response to a court order, subpoena, warrant, summons or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or

(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information 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 (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;

(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

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, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

For the most up to date version of this Marketplace notice, visit the dol link here.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 for coverage starting as early as January 1.

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Spring Arbor University		4. Employer Identification Number (EIN) 381359569
5. Employer address 106 E Main St,		6. Employer phone number 517-750-6575
7. City Spring Arbor	8. State MI	9. ZIP code 49283
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address SpringArbor.HR@arbor.edu	

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

If you are regularly scheduled to work at least 30 hours per week, you are eligible for the Spring Arbor University benefits program.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

- Your legal spouse. A legal spouse is a person of the opposite biological sex to whom you are married at the relevant time by a religious or civil ceremony under the laws of the state in which the marriage was contracted.
- Your children (including your adopted, biological, and step-children) up to the end of the month in which they turn 26
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

☐ 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.

NOTES

MarshMcLennan Agency