Mission Statement:

"To equip students for meaningful lives and productive careers"

University of Findlay

2021 Employee Benefits Guide

Resources to take care of your present and prepare for your future

The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Consult the Summary Plan Descriptions to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plans. In case of a conflict between your plan documents and this information, the plan documents will govern. The availability of a plan or program may vary by geographic service area.

Employee Benefits Enrollment & Eligibility

University of Findlay offers an excellent selection of benefits for benefit eligible employees.

This Employee Benefits Enrollment Guide is designed to familiarize you with the benefits that are available to you. Benefits are a significant part of your total compensation package. It is important to be aware of the benefits and the value they represent.

Eligibility

Employees working full-time 30 hours or more a week are eligible to participate in the University of Findlay Employee Benefits Program. For most of our benefit plans your coverage will become effective on your date of hire. You must be actively working for your coverage to be effective on your eligibility date. You may also enroll your eligible dependents in the University of Findlay Benefit Plans. Your eligible dependents include your spouse (see spousal eligibility clause on page 3) as well as your dependent children, whether natural, adopted, stepchildren, foster or those for whom you have legal custody by court decree. When enrolling in medical, dental or vision coverage, you may enroll any dependent child up to age 26.

What is Open Enrollment?

Open Enrollment is a once-a-year opportunity to make changes to your current benefits and to review which dependents you will be covering during the new plan year. All changes you request will take effect January 1, 2021.

Enrollment Deadline:
Sunday, November 15th

Making Election Changes During the Year?

In most cases, your benefit elections remain in effect until the next annual open enrollment period. You will not be able to make any plan changes unless you experience a life status change.

Life Status Change Events

Events described in IRS regulations allow you to make a change to your benefit coverage if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment / ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

You have 30 days from the date of the Life Status Change event to report and update your benefits with the Office of Human Resources.

What's new this year?

We are happy to inform you that benefits will remain exactly the same as what is currently in place. If you are enrolled in our Voluntary Life insurance benefits, the payroll deduction may change if you enter a new age band or have experienced a salary adjustment in the last twelve months. You can find rate information on pages 13 & 14 of this enrollment guide.

Frequently Asked Questions

What is a Deductible?
A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for health care services rendered. For example, if you have a $1,500 deductible, you would be required to pay the first $1,500, in total, of any claims during a plan year. The deductible excludes copayments where applicable.

What is Coinsurance?
Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible.

How do I know when to go to an Urgent Care Center vs. the Emergency Room?
If you need medical care when your regular doctor is not available, think about going to an urgent care center. The urgent care center should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out -of-town. The cost is less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for true emergencies such as broken bones, vigorous bleeding or severe pain.

The next time you are faced with deciding where to go, be sure to evaluate all your options and choose the setting that best suits your illness or injury. **Remember, TeleDoc and our Cosiano Health Center is available to you.** Of course, in a true emergency, seek the appropriate care without delay.

What is Out-Of-Pocket Maximum?
The maximum amount (deductible and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

What is an Explanation of Benefits?
An EOB (Explanation of Benefits) is a description the insurance company sends to you explaining the health care charges you have incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.

What is Preventive Care?
Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early.

Remember, all preventive care benefits are covered 100% under all three medical plan options, as long as you visit an in-network provider.

What is the difference between generic and brand name drugs?
The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money and provide the same health benefits as brand name drugs.

What is the benefit of Mail Order Drugs?
Mail order drugs are perfect for patients who take medication on an ongoing basis. Examples are high blood pressure medication, high cholesterol medication, insulin and birth control. Mail Order drugs are convenient because they are delivered to your doorstep which relieves the stress of standing in line at the pharmacy.

What should I ask my doctor?
Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.

Have Questions? Need Help?

Benefit Resource Center

With the ever-increasing cost of providing benefits and the expansion of consumer directed health plans, employers are looking for ways to improve employee access to benefit information, reduce costs and increase accountability for benefit choices. Since internal resources are often limited, many look to outsource administration and communication functions.

That's why we've developed the Benefit Resource Center. Our toll-free one-call benefits information hotline was specifically designed to act as a single point of contact for all benefit questions and claim issues. Outsourcing benefit questions and claim issues helps streamline your benefit administration and cut costs, while providing your employees and families with better benefit-related support services.

Our seamless integration with your human resources department frees your staff from many time-consuming benefit administration duties.

Benefit Specialists

Our Benefit Resource Center is staffed with experienced professionals who are well versed in employee benefits. They are committed to providing superior customer service and participant advocacy.

Our Benefit Specialists will be able to:

- Answer benefit plan/policy questions
- Assist with eligibility and claim problems with carriers
- Provide claim appeals information and explain the process
- Explain allowable family status election changes (adding newborns, marriage, divorce, etc.)
- Provide vendor plan contact information

You can contact the Benefit Resource Center at 855-874-0829 or via e-mail at BRCMidwest@usi.com. They are available 8am – 5pm EST & CST.

Working Spouse Eligibility

A spouse of a University of Findlay employee is required to participate in their employer sponsored health care plan if the spouse has access to continuous group health coverage through their employment, and the employer contributes at least 50 percent of the premium.

If these conditions are met, the spouse must enroll in their employer's health care plan. The spouse will be permitted to remain on the University of Findlay's plan for secondary health care coverage.

This rule does not apply if your spouse is:

- Not employed
- Self employed
- Is not offered medical coverage at their employer
- Both you and your spouse work for the University of Findlay

Medical Benefits

University of Findlay offers three medical plans administered by UMR. Medical Plans feature a deductible, office visit copayment, prescription drug coverage and coinsurance for certain services.

Through these plans you have access to thousands of network physicians and hospitals in the United States. You, the employee, and your dependents are responsible for ensuring the providers that you utilize are **In Network**. To access a listing of providers, logon to www.umr.com

	Orange PPO	Black PPO	High Deductible Plan HDHP (non-creditable)
Medical Benefit	**In Network**	**In Network**	**In Network**
Deductible Type	Embedded	Embedded	Non-Embedded
Deductible (You Pay)	• Tier 1 (BVHS)- $500 per person $1,000 max per family • Tier 2 (UHC Choice) - $750 per person $1,500 per family • Tier 3 (OON) - $1,000 per person, $2,000 per family	• Tier 1 (BVHS)- $1,000 per person $2,000 max per family • Tier 2 (UHC Choice) - $1,500 per person $3,000 per family • Tier 3 (OON)- 2,000 per person $4,000 max per family	• Tier 1 (BVHS)- $2,500 Single $5,000 max per family • Tier 2 (UHC Choice) - $3,000 Single $6,000 per family • Tier 3 (OON)- $5,000 Single $10,000 max per family
Coinsurance (Insurance Pays)	• Tier 1 (BVHS)– 85% of medical charges after you meet deductible • Tier 2 (UHC Choice) - 75% of medical charges after you meet deductible • Tier 3 (OON) – 55% of your medical charges after deductible has been met	• Tier 1 (BVHS) – 85% of medical charges after you meet deductible • Tier 2 (UHC Choice) - 75% of medical charges after you meet deductible • Tier 3 (OON) - 55% of medical charges after you meet deductible	• Tier 1 (BVHS) – 85% of medical charges after you meet deductible • Tier 2 (UHC Choice) - 75% of medical charges after you meet deductible • Tier 3 (OON) - 55% of medical charges after you meet deductible
Out of Pocket Maximum (You Pay)	• Tier 1 (BVHS) - $1,500 per person $3,000 max per family; • Tier 2 (UHC Choice) - $2,500 per person $5,000 per family • Tier 3 (OON) - $4,000 per person $8,000 max per family The deductible is included in the out of pocket max.	• Tier 1 (BVHS) - $3,000 per person $6,000 max per family; • Tier 2 (UHC Choice) - $4,000 per person $8,000 per family • Tier 3 (OON) - $6,000 per person $12,000 per family The deductible is included in the out of pocket max.	• Tier 1 (BVHS) - $3,000 Single $6,000 max per family; • Tier 2 (UHC Choice) - $3,425 Single $6,850 per family • Tier 3 (OON) - $7,000 Single $14,000 per family The deductible is included in the out of pocket max.

Medical Benefits (Cont.)

Please note: Tier 1 is Hospital Services at Blanchard Valley Hospital System, Tier 2 UHC Choice and Tier 3 is Out of Network.

	Orange PPO	Black PPO	High Deductible Plan HDHP (non-creditable)
	Your cost after deductible	**Your cost after deductible**	**Your cost after deductible**
Physician Office Visit & Specialist	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%
Preventive Care	100%	100%	100%
Emergency Room	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%
Inpatient Hospital and Outpatient Surgery/Services	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%
Lab/X-Ray	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%	Tier 1 (BVHS) – 15% Tier 2 (UHC Choice) – 25% Tier 3 (OON) – 45%
Retail Drugs (You Pay) ***Orange and Black Plans do not have Tier Cost for RX**	*Prescription Drug separate Out of Pocket Maximum: $1,250 per person/$2,500 per Family • Level 1: $8 copay • Level 2: $22 copay or 25%, whichever is greater • Level 3: $42 copay or 30%, whichever is greater • Specialty: 50%	*Prescription Drug separate Out of Pocket Maximum: $1,250 per person/$2,500 per Family • Level 1: $10 copay • Level 2: $30 copay or 25%, whichever is greater • Level 3: $50 copay or 30%, whichever is greater • Specialty: 50%	Included with Medical Tier 1: 15% after deductible Tier 2: 25% after deductible Tier 3: 45% after deductible
Mail Order Drugs (You Pay) ***Orange and Black Plans do not have Tier Cost for RX**	Mail order 2x Retail • Level 1: $16 copay • Level 2: $44 copay or 25%, whichever is greater • Level 3: $84 copay or 30% whichever is greater	Mail order 3x Retail • Level 1: $30 copay • Level 2: $90 copay or 25%, whichever is greater • Level 3: $150 copay or 30%, whichever is greater	Included with Medical Tier 1: 15% after deductible Tier 2: 25% after deductible Tier 3: 45% after deductible

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the health plan. Refer to the benefit summary or certificate of coverage for more information.

Imaging Program

Non-emergency, outpatient MRI and CT Scans will be subject to a benefit maximum.

	With Contrast	Without Contrast	With and Without Contrast
MRI	**$800**	**$600**	**$1,200**
CT	**$500**	**$400**	**$600**

- In the event of a non-emergency outpatient imaging procedure, all employees and dependent family members on the plan are encouraged to obtain the procedure at a cost-effective facility.
- Members should use the My Healthcare Cost Estimator to locate providers or call UMR Customer Service.
- If the facility bills more than the maximum, the provider could balance bill you.
- If you are balance billed and feel there was not an alternative imaging facility within a reasonable geographic range, or the additional fees were related to medical necessity, you can appeal the claim to UMR.

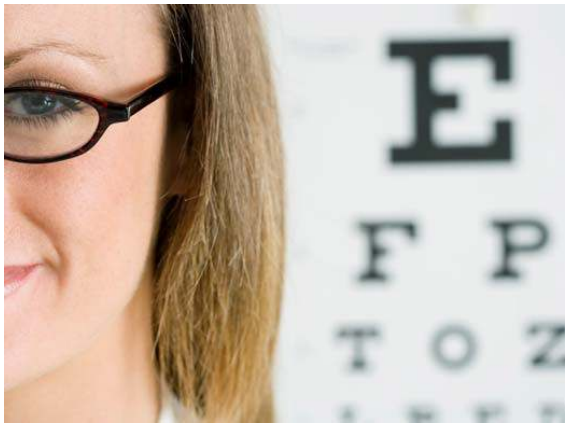
Dental Benefits

The dental plan is administered by UMR. The details of your plan are below.
Refer to the benefit summary or certificate of coverage for more information.

Dental Benefit	Dental PPO
Deductible (You Pay)	$50 per person $100 family maximum
Benefit Maximum	$1,500 maximum per person
Preventive Services	100% Insurance pays 100% for oral exams, x-rays and cleanings Annual Limits Apply
Basic Services	After deductible is met, insurance pays 80% Services include fillings, extractions, periodontics, root canals and general anesthesia
Major Services	After deductible is met, insurance pays 60% Services include crowns, dentures, fixed and removable prosthetics
Annual Maximum Benefit	$1,500
Orthodontia Care (dependent children only)	50%
Orthodontia Lifetime Maximum	$1,500

Vision Benefits

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Go anywhere in the network for an exam, but we suggest you use a major retail chain when getting your frames and lenses.



The vision plan is administered by Metlife which offers a Preferred Provider Network for you to choose a vision care provider. To access a listing of providers (private practice and retail centers) logon to www.metlife.com

The benefits are below. Look them over. If they seem fuzzy, it might be time to sign up and utilize them!

Vision Benefit	In Network	Out of Network
Vision Exam	$10 copay	Your coverage out of network will be less or you will receive a lower benefit.
Materials	$25 copay	Your coverage out of network will be less or you will receive a lower benefit.
Exams	100%	Up to $45
Benefit after Copay		
Single Vision Lenses	100%	Up to $30
Bifocals Lenses	100%	Up to $50
Trifocals Lenses	100%	Up to $65
Contact Lenses (Instead of prescription glasses)	100% to $130 allowance; 20% off balance	Up to $105
Frames	100% to $130; allowance; 20% off balance	Up to $70
Frequency of Services		
Vision Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contacts	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months

Refer to the benefit summary or certificate of coverage for more information.

Income Protection Benefits

Basic Life and AD&D Insurance

University of Findlay provides a Basic Life and AD&D benefit to eligible employees through Metlife. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Life & AD&D	Description
Life (Employee)	$50,000
AD&D	In the event of an accidental dismemberment, a benefit is provided up to a scheduled amount corresponding to the loss. Please see your booklet for further details.

Refer to the benefit summary or certificate of coverage for more information.

Disability coverage

University of Findlay provides a company sponsored, long-term Disability plan through Metlife.
The greatest threat to your earning power is illness or injury. If you are disabled for 90 days or longer due to a non-occupational illness or injury, University of Findlay provides you with LTD benefits at no cost to you. The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability. University of Findlay pays the premiums for this plan. Highlights of the LTD plan include the following:

Long-Term Disability	Description
Benefit Waiting Period	90 days from the day the disability begins
Monthly Benefit	60% of your monthly earnings Earnings includes your basic monthly earnings and commissions in effect prior to your period of disability. It does not include bonuses or overtime pay.
Maximum Monthly Benefit	$11,000
Maximum Benefit Duration	Social Security normal retirement age
Pre-Existing Limitation	12 months for conditions treated within the 3 months prior to effective date of coverage

Evidence of Insurability	You will be required to submit Evidence of Insurability for long-term disability, if you declined coverage during your initial eligibility period and would like to enroll for disability coverage now.
Plan administered by Metlife	

Refer to the benefit summary or certificate of coverage for more information.

Income Protection Benefits

Voluntary Life insurance for you and your family

Death. It's not the most popular topic but it's inevitable for us all. Preparing for that day is our responsibility. One way is through providing financially for loved ones. Life insurance offers that gift. Voluntary life insurance for employees and their families is available at discounted group rates. This life insurance plan will cover you or a covered family member in the event of a death while covered by the plan.

Your designated beneficiary is the person(s) to whom you have assigned your life benefits. It is important to provide clear beneficiary selection(s) to the insurance carrier. Please be sure to complete the beneficiary section of your enrollment form to avoid any potential problems for your beneficiaries. You, the employee, are automatically listed as the beneficiary on any policy for your spouse or child/ren.

Coverage	Description
Benefit Amount (Employee)	Units of Increments of $10,000 up to 5 times salary to a maximum of $500,000
Benefit Amount (Spouse)	Units of Increments of $5,000 but not more than 50% of employee amount to a maximum of $50,000 Election cannot exceed 50% of employee's coverage amount
Benefit Amount (Child/ren)	Age 15 days to (25 if FTS): Options of $10,000
Guarantee Issue Amounts	Employee -$250,000 Spouse - $30,000 Child - $10,000 Voluntary Life guarantee issue amounts only apply to new hire employees electing coverage within their original eligibility period. All others will be subject to Evidence of Insurability and can be declined for coverage.
Evidence of Insurability	**You will be required to submit Evidence of Insurability if:** • You declined voluntary life for you or your dependents during your initial eligibility period and would like to enroll for coverage now. • You elect to increase your current election.
Seatbelt Benefit	Life insurance pays an additional benefit if a seatbelt fails to protect an insured person. If that person is wearing a properly fastened seatbelt in a private passenger car accident and dies as a result of the accident, that person's benefit amount will be increased by 10%, but no less than $1,000 and no more than $10,000.
Accelerated Death Benefit	If you or your covered spouse is diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for up to 50% of the coverage amount in force or $50,000, whichever is less, to be paid to the insured. This benefit is payable only once in an insured's life-time and will reduce the life insurance death benefit.
In order to purchase Voluntary Life for Spouse and Children you must buy coverage for yourself.	
Plan administered by Metlife	

Refer to the benefit summary or certificate of coverage for more information.

Accident, Critical Illness and Hospital Indemnity Insurance

Recent studies have shown that:

- 42% of all personal bankruptcies are a result of medical expenses.
- The average cost for one visit to the emergency room in the U.S. is $1,233.
- 33% of US adults will be diagnosed with cancer at some point in their lives.

Plan Options that are tailored to meet your needs:

- Guaranteed issue coverage for employees, spouses and children. Because family is important.
- Benefits are paid regardless of what's covered by medical insurance.
- Lump sum paid directly to you as the employee to spend as you choose.
- Portable coverage that you can take wherever you go.
- Value-added services like online will preparation, digital legacy app, funeral planning services and vision discounts — at no cost to you.

What you need to know about MetLife's Accident coverage:

- Over 150 covered events and services, such as fractures, dislocations and medical treatments or tests.
- You and your eligible family members are guaranteed coverage. No medical exam and no hassle.
- Lump-sum payment helps cover unexpected costs that result from an accident.
- For your convenience, premiums will be automatically deducted from your paycheck.

What you need to know about MetLife's Hospital Indemnity coverage:

- You and your eligible family members are guaranteed coverage. No medical exam and no hassle.
- Lump-sum payment can be used to help cover unexpected costs that result from a hospitalization.
- For your convenience, premiums will be automatically deducted from your paycheck

What you need to know about MetLife's Critical Illness coverage:

- Over 20 covered critical illnesses, such as Cancer, Heart Attack, Stroke and Kidney Failure.
- You and your eligible family members are guaranteed coverage. No medical exam and no hassle.
- Lump-sum payment can be used however you want, including to help cover unexpected costs that result from a covered critical illness.
- For your convenience, premiums will be automatically deducted from your paycheck.

Flexible Spending Accounts (FSA)

You can set aside tax-free dollars each year to cover eligible out-of-pocket health care and daycare expenses. The plan is comprised of a health care spending account and a dependent care account. Each account is separate; you cannot use health care funds to pay for dependent care expenses or vice versa. You can elect to participate in one or more accounts, or you can waive coverage.

How the Plans Work

- You elect a contribution amount to deduct from your pay on a before-tax basis and put into the flexible spending account
- You may not change your contribution amount during the plan year unless it is consistent with a change in family status
- Expenses must be incurred within the enrollment period
- You may submit claims for expenses incurred within the enrollment period

It is important to plan your contribution amounts carefully. The Internal Revenue Service requires that you forfeit any money for which you have not incurred eligible expenses by the end of the plan year.

Health Care FSA

Funds that you set aside in a Health Care FSA can be used to reimburse yourself for eligible health care expenses not covered under the medical, prescription drug, dental or vision plans. Reimbursements can be made for most expenses that would qualify for a health care deduction on your income tax return.

Dependent Care Spending Account

A Dependent Care Account can be used to pay for certain child/day care, or elder care expenses incurred during the plan year. Your dependent care expenses must be necessary in order for you and your spouse to work or actively look for work or attend school as a full-time student.

Eligible Dependent Care Expenses

- Childcare for a dependent age 13 or less, provided at a day care center or through a private provider
- Childcare for a dependent over age 13 if he/she is physically or mentally incapable of caring for him or herself
- Nanny services in the home associated with the care of a dependent
- Day camps associated with the care of a dependent
- Pre-school tuition that is day care related (price of tuition alone is not eligible)
- After-hours care that results from working odd hours or overtime

Dependent Care claims will be reimbursed only up to your account's current balance. If a dependent care expense exceeds the dependent care balance, you'll be reimbursed the additional amount as contributions are made to your account through your payroll deductions.

Benefit Coverages	Maximum Amount
Health Care FSA	$2,750
Dependent Care FSA	$5,000/Single or Married Filing Jointly or $2,500/Married and Filing Separately

Limited Purpose Flexible Spending Account

Limited purpose FSA's aren't intended to be used for the same wide range of expenses covered by HSA's. Instead, they're designed to be limited to just dental and vision expenses – oftentimes, specific expenses as defined by the limits of the plan.

Limited purpose FSA's aren't intended to replace traditional HSA's, which is why they only cover vision and dental expenses. Medical expenses, such as prescription medications and emergency room visits, are not covered by the limited purpose FSA.

Employee Contributions

Medical, Dental and Vision Rates:

Bi-Weekly Payroll Deductions					
Coverage Level	Medical PPO Orange Plan –	Medical PPO Black Plan -	Medical PPO HSA Plan -	Dental PPO	Vision
Employee Only	$125.39	$103.90	$53.21	$4.85	$4.32
Employee + Spouse	$244.21	$202.36	$103.63	$11.77	-
Employee + Child(ren)	$217.15	$179.93	$92.15	$11.77	-
Family	$325.09	$269.62	$138.09	$11.77	-
Employee + 1 Dep					$6.54
Employee + 2+ Deps					$11.68

Voluntary Life Insurance Rates:

Voluntary Life RATES (Monthly)		
Employee Age	Employee Monthly Cost per $1,000	Spouse Monthly Cost per $1,000
Under 25	$0.040	$0.040
25 - 29	$0.040	$0.040
30 - 34	$0.050	$0.050
35 - 39	$0.070	$0.070
40 - 44	$0.110	$0.110
45 - 49	$0.180	$0.180
50 - 54	$0.300	$0.300
55 - 59	$0.490	$0.490
60 - 64	$0.660	$0.660
65 - 69	$1.040	$1.040
70 - 74	$1.840	
75 - 79	$1.840	
Over 80	$1.840	
Composite		
Per $1,000 Child Life	$0.170	

Employee Contributions

Critical Illness Premium Structure

Bi-Weekly Premium for $10,000 of Coverage

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$2.58	$4.34	$4.15	$5.91
25–29	$2.72	$4.52	$4.29	$6.09
30–34	$3.42	$5.58	$4.98	$7.15
35–39	$3.83	$6.23	$5.40	$7.80
40–44	$4.43	$7.15	$6.00	$8.72
45–49	$6.28	$9.97	$7.85	$11.54
50–54	$8.82	$13.94	$10.38	$15.51
55–59	$12.28	$19.25	$13.85	$20.82
60–64	$16.57	$25.85	$18.14	$27.42
65–69	$22.71	$35.40	$24.28	$36.97
70+	$33.37	$51.65	$34.94	$53.22

Critical Illness Premium Structure

Bi-Weekly Premium for $20,000 of Coverage

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$5.16	$8.68	$8.30	$11.82
25–29	$5.44	$9.04	$8.58	$12.18
30–34	$6.84	$11.16	$9.96	$14.30
35–39	$7.66	$12.46	$10.80	$15.60
40–44	$8.86	$14.30	$12.00	$17.44
45–49	$12.56	$19.94	$15.70	$23.08
50–54	$17.64	$27.88	$20.76	$31.02
55–59	$24.56	$38.50	$27.70	$41.64
60–64	$33.14	$51.70	$36.28	$54.84
65–69	$45.42	$70.80	$48.56	$73.94
70+	$66.74	$103.30	$69.88	$106.44

Group Hospital Insurance:

Plan	Bi-Weekly
Employee Only	$9.30
Employee + Spouse	$19.05
Employee + Children	$15.55
Employee + Spouse/Children	$25.30

Group Accident Insurance:

Plan	Bi-Weekly
Employee Only	$4.64
Employee + Spouse	$8.96
Employee + Children	$9.66
Employee + Spouse/Children	$12.09

Employee Contact Directory

University of Findlay - Human Resources
419-434-6964

UMR (TPA) – Medical, Dental & Flexible Spending Account
www.umr.com
1-866-414-1959

Metlife – Vision, Life & Disability
www.metlife.com
1-800-438-6388

University of Findlay

Important Legal Notices

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 08 for more details.

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Orange Plan: Deductible: Individual $750, Family $1,500, 75/25%; Black Plan: Individual $1,500, Family $3,000, 75/25%; HDHP/HSA: Individual $3,000, Family $6,000, 75/25%

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or 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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within30 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.

- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Kimberly Henley
1000N. Main Street
Findlay, Ohio 45840
419-434-4804
henley@findlay.edu

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.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- 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/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2021
- Kimberly Henley, Assistant Director of HR, henley@findlay.edu, 419-434-4804

Important Notice from University of Findlay About Your Prescription Drug Coverage and Medicare – Black & Orange PPO Plans

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of Findlay 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. **University of Findlay has determined that the prescription drug coverage offered by the UMR Black & Orange Plans 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, your current University of Findlay coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current University of Findlay coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 University of Findlay 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 University of Findlay 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:	01/01/2021
Name of Entity/Sender:	University of Findlay
Contact--Position/Office:	Kimberly Henley, Assistant Director of HR
Address:	1000 N. Main Street, Findlay, OH 45840
Phone Number:	419-434-4804

Important Notice from University of Findlay About Your Prescription Drug Coverage and Medicare – UMR HDHP

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of Findlay 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. **University of Findlay has determined that the prescription drug coverage offered by the UMR HDHP is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the UMR HDHP. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. **You can keep your current coverage from UMR HDHP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – It explains your options.**

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.

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

Since the coverage under UMR HDHP, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have

Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current University of Findlay coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current University of Findlay coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 University of Findlay 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).

Date:	01/01/2021
Name of Entity/Sender:	University of Findlay
Contact--Position/Office:	Kimberly Henley, Assistant Director of HR
Address:	1000 N. Main Street, Findlay, OH 45840
Phone Number:	419-434-4804

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

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

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

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

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

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.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 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

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

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

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 University of Findlay	4. Employer Identification Number (EIN) 34-4431169	
5. Employer address 1000 N. Main Street	6. Employer phone number 419-434-4804	
7. City Findlay	8. State Ohio	9. ZIP code 45840
10. Who can we contact about employee health coverage at this job? Kimberly Henley		
11. Phone number (if different from above)	12. Email address henley@findlay.edu	

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Working Full-Time 30 hours a week.
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:
    - Spouse
    - dependent children, whether natural, adopted, stepchildren, foster, or those for whom you have legal custody by court decree up to age 26.
  - [ ] We do not offer coverage.

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)