Employee Benefits Guide 2024

LUTHERAN SOCIAL SERVICES
of Northwestern Ohio

Strengthening People in Body, Mind and Spirit

This booklet is intended as a high level overview and is for informational purposes only. The plan documents, contribution schedules, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

IMPORTANT CONTACTS

BENEFIT CONSULTANT

HYLANT

General Claims and Benefit Information

Jan Roberts 419-259-2708

jan.roberts@hylant.com

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, provider invoice/billing statement, a denial letter, etc.

Questions About	Contact	Phone	Website
Medical Claims Payor	Blackhawk	888-205-2688	www.blackhawktpa.com
Prescription Drug	BMR (Broadreach Medical Resources)	877-718-2379, Opt. 4 (Member Services)	https://members.bmr-inc.com
Network	Frontpath		Network web address www.frontpathcoalition.com/provider-directory/
Dental	Delta Dental	800-524-0149	www.deltadentaloh.com
Vision	DeltaVision thru VSP	800-877-7195	www.vsp.com

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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 21 for more details.

ENROLLING IN BENEFITS
OVERVIEW

OPEN ENROLLMENT
This Benefits Guide provides an overview of your benefit options and additional information to help you make your enrollment decisions.

IMPORTANT: This is an "Active Enrollment". You are required to complete the appropriate application during the Open Enrollment period by completing the enrollment process detailed below. If you do not make elections during Open Enrollment, you and your dependents may not have coverage.

Learn More

GETTING STARTED: EVALUATE
When reviewing your benefit options, you should take into account your expected total annual healthcare cost, which includes your plan contributions plus your expected out-of-pocket costs, such as deductibles, coinsurance and copays. You should also consider healthcare plan features that are important to you and how you prefer to pay for coverage (i.e., less up front in contributions but more out-of-pocket should you need unexpected care vs. more upfront in contributions but less out-of-pocket should you need unexpected care).

Use the websites and phone numbers in the *Important Contacts* section to see which doctors and other healthcare providers you can use under your plan choices. If you have dependents that live out of state, check on provisions for coverage of members away from home.

ENROLL: MAKING YOUR ELECTIONS
Review your current benefit elections/enrollment. If you need to make changes, you must complete the appropriate enrollment forms and return them to the Director of HR.

ACTION ALERT:

Choose your benefits wisely! After the enrollment deadline, benefit elections cannot be changed or canceled until the next enrollment period unless a qualifying event occurs.

ELIGIBILITY

As a benefits-eligible employee, Lutheran Ministries of Mercy (Lutheran Social Services of Northwestern Ohio) offers a health and welfare program that offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical	√	Up to age 26
Dental	√	Up to age 26
Vision	√	Up to age 26

DEPENDENT VERIFICATION

You may be asked to provide Human Resources proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

NEW HIRE COVERAGE

As a new employee you have 30 days from date of hire to make your benefit elections. It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event. Following enrollment, you are eligible the first day of the month following your hire date.

TERMINATION OF COVERAGE

If employment is terminated, all coverage will end on the last day of the month.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

WELCOME BABY! Don't forget to notify Human Resources within 30 days of birth of a newborn to add dependent(s) to the plan.

Learn More

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify Human Resources of such change(s) within the noted days from the event as shown in the below table. Failure to notify Human Resources within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Human Resource representative.

Qualifying Event	Timeframe to Notify Human Resources*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

** days from the qualifying event*

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Employees more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

COST OF COVERAGE SUMMARY

2024 (26 PAYS) PAYROLL DEDUCTIONS

	Employee	Employee + Spouse*	Employee + Child	Family
MEDICAL				
Gold 200 - $1,000 PPO Plan	$105.06	$234.12	$189.31	$249.13
DELTA DENTAL				
Voluntary Dental PPO	$8.30	$16.93	$22.41	$31.08
DELTAVISION thru VSP				
Voluntary Vision	$2.69	$5.37	$5.75	$9.18

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with “before-tax” dollars (e.g., medical, dental and vision coverage). By paying premiums with “before-tax” dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you have to notify Human Resources if you intend to make a change.

HEALTH & WELL-BEING COVERAGE

MEDICAL

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage or SBC. You may access a list of participating providers through the carrier's website.

www.frontpathcoalition.com 888-205-2688

BENEFITS AT-A-GLANCE

Look for a participating provider in the following network: Frontpath

	Gold 200 - $1,000 PPO Plan	
	In-Network	**Out-of-Network**
DEDUCTIBLES	Calendar Year	
Individual	$1,000	$2,500
Family	$2,000	$3,000
COINSURANCE		
Plan Pays	80%	50%
You Pay	20%	50%
Individual	$3,500	$7,000
Family	$7,000	$14,000
Primary Physician Visit	$15 copay	50% after deductible
Specialist Visit	$40 copay	50% after deductible
Telemedicine	$0 copay	50% after deductible
Preventive Care Services	100% coverage	50% after deductible
Urgent Care Visit	$40 copay	50% after deductible
Emergency Room	$300 copay	$300 copay
Emergency Room – *Non-Emergent Care*	$500 copay	50% after deductible
Diagnostic Labs & X-Rays / Office & Freestanding Outpatient	80% after deductible	50% after deductible
Hospitalization	80% after deductible	50% after deductible
Mental Health* / Inpatient & Outpatient Facility / Office Visit	80% after deductible	50% after deductible
Substance Abuse* / Inpatient & Outpatient Facility / Office Visit	80% after deductible	50% after deductible
PRESCRIPTION DRUGS – 30 DAY SUPPLY AT RETAIL PHARMACY**		
Tier 1 - Generic	$0 copay	N/A
Tier 2 - Formulary Generic	$35 copay or 25%, whichever is greater	N/A
Tier 3 – Non-Formulary Brand	$75 copay or 45%, whichever is greater	N/A
Tier 4 - Specialty	$200 copay or 30%, whichever is greater	N/A

**See Summary Plan Description for additional details. You may also contact your HR department regarding benefits.*
***90-day mail order available*

ABOUT PREVENTIVE CARE:

Most preventive care services are covered 100% at no cost to you. Preventive care services include regular checkups, screenings, vaccinations and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps that can improve the well-being of you and your family.

IMPORTANCE OF A PRIMARY CARE PHYSICIAN (PCP)

YOUR PARTNER IN HEALTH

Primary care doctors may provide you medical care over a long period of time, help you stay healthy, coordinate your care and recommend other providers, such as specialists, when needed.

CHOOSE THE RIGHT PCP

Choosing a doctor is a very important decision requiring care and consideration. Take advantage of the tools and resources through your medical plan such as provider directories for network providers, maps, and quality ratings to research your options. Asking friends, co-workers or relatives is also helpful when selecting a PCP. For information on specific physicians' training, specialties and board certification you can also visit the American Medical Association at www.ama-assn.org.

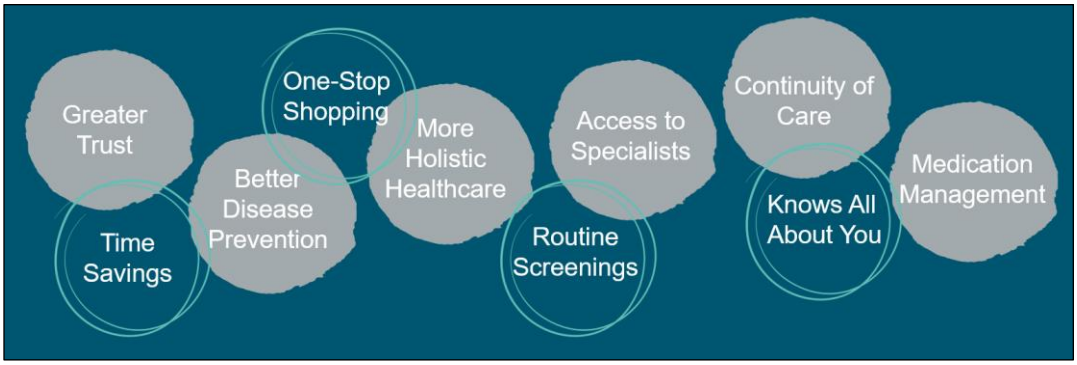
Once you have made your selection, it is important to call your primary care physician for an appointment to establish yourself as a patient. This is a valuable step that may prevent potential wait time in scheduling future appointments.

WHAT DOES A PCP DO?

A primary care provider is your main healthcare provider in nonemergency situations. Starting with preventive care, he or she coordinates the care you need and helps you address health issues before they become a more serious problem. PCPs conduct regular checkups, routine screenings and immunizations, provide patient education, offer advice on preventing disease, as well as overseeing specialty care, lab tests and hospitalization.

BENEFITS OF HAVING A PCP

In addition to the benefits and cost-savings of having an in-network provider, a PCP will help you navigate the healthcare system so you can concentrate on your health. Even if a plan doesn't require you to have a PCP, it's a good idea to choose one. Because of routine tests and regular visits, your PCP will know how to help you stay focused on self-care.



ESTABLISH A RELATIONSHIP WITH YOUR PCP

Having a well-established, trusting relationship with your doctor is crucial to your long-term health, and can also save you money in the long run. Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive.

Tell your doctor about your health history, your family's health history, symptoms, medications and any allergies you have. If you do not share relevant information, your doctor may not ask or may assume there is nothing important he or she needs to know. Withholding information may make it difficult for your doctor to determine the best care route for you to take. The more comfortable you are, the more you'll share — and that can be good for your health in the long run.

Your doctor works hard to keep you healthy, but quality healthcare is a team effort. Make sure to ask questions if you don't understand what your doctor is recommending. This is especially important to do before receiving health services. Not every plan is the same, so it's important to ask questions to avoid confusion and unexpected costs later. If you are confused about anything your doctor recommends, don't be afraid to ask questions.

EMERGENCY ROOM OR URGENT CARE

KNOW WHERE TO GO

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office.

If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

EMERGENCY ROOM	URGENT CARE
The **emergency room (ER)** is equipped to handle life- threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.	**Urgent care centers** are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.
You should go to the nearest ER if you experience any of the following: • Compound fractures • Deep knife or gunshot wounds • Moderate to severe burns • Poisoning or suspected poisoning • Seizures or loss of consciousness • Serious head, neck or back issues • Severe abdominal pain • Severe chest pain or difficulty breathing • Signs of a heart attack or stroke • Suicidal or homicidal feelings • Uncontrollable bleeding	Some examples of conditions that require a visit to an urgent care center include: • Controlled bleeding or cuts that require stitches • Diagnostic services (x-rays, lab tests) • Ear infections • High fever or the flu • Minor broken bones (e.g., toes, fingers) • Severe sore throat or cough • Sprains or strains • Skin rashes and infections • Urinary tract infections • Vomiting, diarrhea or dehydration

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

DON'T PAY MORE IF YOU DON'T HAVE TO:

Convenience Care Clinics are walk-in clinics typically located in a supermarket, pharmacy or retail store, where available. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit copays and/or coinsurance. Convenience care clinics are suitable for non-life threatening immediate care. *Examples include: common infections (ear, bladder, pink eye, strep throat), minor skin conditions, allergies, and more.*

PHARMACY RESOURCES

SAVE ON PRESCRIPTION COSTS

Many pharmacies now offer discount prescriptions – maybe even lower than your copay.

Pharmacies nationwide sell select generic drugs at a discounted rate. Generic drugs are distributed as the equivalent to the brand name; however, you should talk to your doctor if you have questions about your prescription. You can find the best deals on your medications by identifying the pharmacies that offer these programs. Here are just a few available:

Sam's Club	Plus members can receive hundreds of generic medications at $4 or $10 for a 30-day supply, and five select prescriptions for free
Walmart	$4 for a 30-day supply and $10 for a 90-day supply of some generic medications
Walgreens	Prescriptions Savings Club where members can get over 50 medications for as low as $5 for a 30-day supply and discounts on vitamins, birth control, diabetic supplies and lifestyle medications
Costco	Member Prescription Program offers savings on brand and generic medications
Meijer	Offers a variety of oral antibiotics for free
Publix	Next Best Thing to Free Program offers a 90-day supply for select generic medications for only $7.50
Giant Eagle	Offers a wide range of generic drugs at $4 or $10 per prescription as well as a 90-day supply for qualified medications

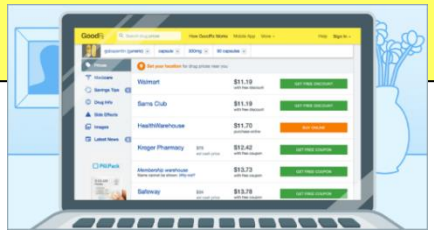
NOTE: Be sure to check with the pharmacy for current discounts and offerings

GoodRx may be an option for less expensive prescriptions **www.GoodRx.com**

"GoodRx" is the #1 prescription app - find the lowest prescription drug prices on-the-go with coupons built into the app and just show your smartphone to the pharmacist to save. If you use this option, it will not apply to your health plan coverage out-of-pocket, co-insurance, deductible, co-pay or any other plan feature.

Free, easy-to-use mobile app features:

- Instant access to the lowest prices for prescriptions at more than 75,000 pharmacies
- Coupons and saving tips that can cut your prescription costs by 50% or more
- Side effects, pharmacy hours and locations, pill images, and much more
- Save up to 80% on pet medications
- Available on the App Store or Google play



DENTAL COVERAGE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage or benefit summary. You may access a list of participating providers through Delta Dental's website.

www.deltadentaloh.com 800-524-0149

BENEFITS AT-A-GLANCE

	Voluntary Dental PPO	
	In-Network	**Out-of-Network**
Look for a participating provider in the following network: Delta Dental Preferred or Delta Dental Premier		
Type I—Preventive Services: exams, cleanings, fluoride and space maintainers, sealants, palliative treatment, brush biopsy, x-rays	100% coverage	100% coverage
Type II—Basic Services: fillings, crown repair, root canals, periodontic services, extractions and dental surgery, other basic services	80% after deductible	80% after deductible
Type III—Major Services: restorative services for crowns, inlays, onlays and veneers, relines and repairs to prosthetic appliances, bridges and denture services	50% after deductible	50% after deductible
Type IV—Orthodontics Up to age 19	50% coverage	50% coverage
DEDUCTIBLE *Waived for Preventive Services*	Calendar Year Deductible	
Individual	$50	$50
Family	$150	$150
MAXIMUM BENEFIT LIMITS		
Annual Limit: Preventive, Basic and Major Services	$1,000	$1,000
Lifetime Limit: Orthodontics	$1,000	$1,000
ANNUAL MAXIMUM ROLLOVER		
Rollover Threshold	$500	
Rollover Amount Non-Network	$250	
Rollover In-network amount	$350	
Rollover Account Limit	$1,000	
Dependent Age Limit	26	

VISION COVERAGE

The following is a summary of your vision benefits. The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. For a more detailed explanation of benefits, please refer to your certificate of coverage or benefit summary. You may access a list of participating providers through VSP's website.

www.vsp.com 800-877-7195

BENEFITS AT-A-GLANCE

	DeltaVision thru VSP - Choice Plan	
	In-Network	**Out-of-Network**
Look for a participating provider in the following network: VSP Choice Plan		
Eye Exams Covered Once Every 12 Months	$10 copay	Up to $45 reimbursement
Frames Covered Once Every 24 Months	$130 allowance	Up to $70 reimbursement
Lenses Covered Once Every 12 Months	$20 copay	Up to $30-100 reimbursement
Contact Lenses (Medically Necessary) Covered Once Every 12 Months	$20 copay	Up to $210 reimbursement
Contact Lenses (Elective) Covered Once Every 12 Months	$130 allowance	Up to $105 reimbursement

HEALTH SAVINGS TIPS

Learn More

STRETCHING YOUR HEALTHCARE DOLLAR

As healthcare costs continue to rise, it is increasingly important that you take an active role in decisions about your health, the care you receive and your benefits. Here are some tips to help get you the most for your money.

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. Your PCP can provide necessary medical advice and identify health concerns before they become a major issue.

STAY IN-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

DON'T SKIP PREVENTIVE CARE

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 the preventive screenings recommended for their age in order to detect health conditions early.

PRICE COMPARE PRESCRIPTIONS

Ask your provider for the generic version of a prescription. If you order your maintenance medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you, or check to ensure prescribed medications are on the plan's formulary list.

LIVE A HEALTHY LIFESTYLE

Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Take advantage of tobacco cessation programs. Take a walk at lunch to manage stress. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.

USE THE PLAN'S TOOLS & RESOURCES

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition and can possibly save you money in the long run. Look for other available resources or programs that are designed to prevent illness and lower health costs over the long run.

Healthcare Bluebook

Healthcare price and quality transparency

Visit www.healthcarebluebook.com and scroll down to select the Free Search Tool. Register to look up the fair value of the service(s) prior to discussing the cost with your healthcare provider.

SEARCH – Any procedure to see what to expect to pay in your area

COMPARE – Bluebook's Fair Price information and quality ranking to make smarter healthcare decisions

SAVE – On Out-of-Pocket costs every time you receive medical care

NOTE: Always confirm the provider and / or facility is in-network

PRESCRIPTION OPIOID AWARENESS

BE INFORMED

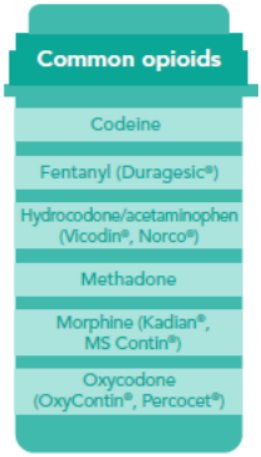
You've no doubt heard that there's a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your healthcare provider to make sure you are getting the safest, most effective care.

KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:



· Make the most informed decision.
· Work with your doctor to create a plan on how to manage your pain.
· Know your options and consider ways to manage your pain that do not include opioids.
· Talk to your doctor about any and all side effects and concerns.
· Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

Never take opioids in greater amounts or more often than prescribed.

Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor.

Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).

Safely dispose of unused prescription opioids.

SIDE EFFECTS

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

Tolerance	Sleepiness/dizziness
Physical dependence	Confusion
Increased sensitivity to pain	Depression
Constipation	Itching and sweating
Low levels of testosterone	
Nausea, vomiting and dry mouth	

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

IMPORTANT TERMS

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. An in-network provider typically may not balance bill you for covered services.

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

Health Savings Account (HSA) A tax-free, individually-owned savings account used to pay for you and your eligible dependents' insurance deductibles and qualified out-of-pocket medical, dental and vision expenses. Account owners must be enrolled in a high deductible health plan and have no access to first dollar coverage such as Medicare or Direct Primary Care. Money deposited in an HSA stays with you, regardless of employer or plan, and unused balances roll over year to year. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

High Deductible Health Plan (HDHP) Also called a "Consumer Driven Health Plan" (CDHP), has lower premiums and higher deductibles than a traditional health plan. With the exception of preventive care, employees must meet the annual deductible before the plan pays benefits even for office visits and prescriptions.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network and the member pays a lower amount for those services.

Mandatory Generic When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference if DAW is written indicated by the prescribing physician.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and possible other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

September 2024
Vice President
Lutheran Social Services of Northwestern Ohio
2149 Collingwood Blvd
Toledo OH 43620
419-243-9178

Name of Group Health Plan: Lutheran Social Services of Northwestern Ohio

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If you are declining 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).

If you have a new dependent as a result of a 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, or placement for adoption. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within **60 days** of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

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. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING PATIENT PROTECTION RIGHTS

Your Group Health Plan (identified at the beginning of this section) does not require the designation of a primary care provider.

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Group Health Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the Plan Administrator (identified at the beginning of this section) or issuer.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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.

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. (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.)

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 your Plan Administrator (identified at the beginning of this section). The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, including online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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, 2024. Contact your State for more information on eligibility:

ALABAMA Medicaid	**ALASKA Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**INDIANA Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 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: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)	KANSAS Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA Medicaid and CHIP	RHODE ISLAND Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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

MEDICARE PART D COVERAGE NOTICE: CREDITABLE COVERAGE – IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner or any dependent resides at a different address than you, please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) 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. The prescription drug coverage offered by the Group Health Plan for Medical Plan Options 1 and 2 (PPO 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 15 through December 7. 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 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 your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 U.S. Social Security on the web at **www.socialsecurity.gov** or call 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).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at https://www.cms.gov/nosurprises/consumers. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

NOTICE OF RECISSION COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

SUMMARY OF BENEFITS & COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on www.medmutual.com. A paper copy is also available, free of charge, by contacting your Plan Administrator (identified at the beginning of this section).

LUTHERAN SOCIAL SERVICES
of Northwestern Ohio

Strengthening People in Body, Mind and Spirit