Querbes & Nelson Since 1914

Centenary College

Insurance Benefits 2017

CENTENARY COLLEGE OF LOUISIANA

Important Contact Information

Querbes & Nelson Insurance Agency

Contact for Service and Benefit Questions
318-221-5241 or 1-800-655-8813
benefits@qnins.com

Callie Ware,	Benefits Account Executive
Direct Line:	318-429-0553
Mobile:	318-272-9686
Email:	cware@qnins.com

Rachel Thrash,	Benefits Group Advisor
Direct Line:	318-429-0516
Mobile:	318-
Email:	rthrash@qnins.com

To Find Network Providers and Pharmacies Visit:
www.bcbsla.com-Network- HMO Louisiana
For Dental and Vision Providers: www.guardiananytime.com

This is intended to be a summary of benefits not a contract. Please consult the insurance contract for more details. If there is a conflict between this summary and the contract, the contract governs.

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Option 1 Medical Plan Highlights - HMO
Effective Date: January 1, 2017

Insurance Company	Blue Cross Blue Shield of Louisiana
Office Visit Copay	$50
Urgent Care Copay	$50
In- Network Individual Deductible	$1,000
In-Network Deductible Family	$3,000
In-Network Co Insurance	20%
In-Network Individual - Out of Pocket Max	$4,000
In-Network Family - Out of Pocket Max	$8,000
Emergency Room Visit	Deductible / copay
Lifetime Maximum	None

Prescription Drugs: Tiers and Co-Pays	
Generic (Tier 1)	$ 10
Brand Name (Tier 2)	$30
Non-Preferred Brand (Tier 3)	$55
Injectibles (Tier 4 & 5)	10% up to $150

MEDICAL Coverage	Monthly Deductions
Employee Only	$210.00
Employee + Spouse	$475.00
Employee + Child(ren)	$558.00
Employee + Family	$696.00

This is an HMO Louisiana plan. There will be no coverage outside of the Louisiana network, except in case of emergency.

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Option 2 Medical Plan Highlights – HDHP HMO
Effective Date: January 1, 2017

Insurance Company	Blue Cross Blue Shield of Louisiana
In-Network Deductible Individual	$1,900
In-Network Deductible Family	$3,800
In-Network Coinsurance	0%
In-Network Individual - Out of Pocket Max	$1,900
In-Network Family - Out of Pocket Max	$3,800
Office Visit	Deductible
Emergency Room Visit	Deductible
Lifetime Maximum	None

Prescription Drugs:	
All Tiers	Deductible

MEDICAL Coverage	Monthly Deductions
Employee Only	$198.00
Employee + Spouse	$466.00
Employee + Child(ren)	$524.00
Employee + Family	$654.00

This is an HMO Louisiana plan. There will be no coverage outside of the Louisiana network, except in case of emergency.

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Guardian	DENTAL PLAN HIGHLIGHTS: Effective January 1, 2017	
	Deductible – Individual (Limit of 3)	$50
	Annual Maximum	$1,500
	Type 1: Preventive & Diagnostic	100%
	Type 2: Basic	90%
	Type 3: Major	60%
	Timely Applicant Wait	Yes
	Ortho (Child)	$1,500

DENTAL Coverage	Monthly Deductions
Employee Only	$15.45
Employee and Spouse	$32.00
Employee and Child(ren)	$45.00
Employee Family	$61.00

Guardian	VISION PLAN HIGHLIGHTS: Effective January 1, 2017	
	In-Network Exam Co-Pay (every 12 months)	$10
	Laser Vision (once per eye per lifetime)	Average 25% discount
	Lenses (single, line bifocal, lined tri, lenticular)	$25 co-pay
	Frames (every 12 mos)	$130 allowance, 30% off the amount over allowance
	Elective Contact Lenses (every 12 mos)	$130 allowance for fitting and materials. If you chooses contact lenses you will be eligible for frames 12 mos from the date contacts were obtained
	Non-Network Exam	Up to $50 allowance
	Non-Network Single Vision Lenses	Up to $48 allowance
	Non-Network Frames	Up to $48 allowance
	Non-Network Contact Lenses	Up to $105 allowance

VISION Coverage	Monthly Deductions
Employee Only	$5.07
Employee and Spouse	$10.14
Employee and Child(ren)	$10.94
Employee Family	$18.56

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Flexible Spending Account:

- Medical Reimbursement Maximum is $2,550 for 2017 (no change)
- Carry Over Amount : $500
- Over the counter medication is not eligible for reimbursement
- Dependent care maximum is $5,000 ($2,500 for married filing separate returns)

403 (b) Retirement plan:

The college matches up to 5% of earnings

Ancillary Benefits Paid by Centenary:

- Basic Life and AD&D: 1x Annual Salary
- Dependent Life
- Long Term Disability
- Short Term Disability
- EAP Plan

Employee Paid Ancillary Options (Guardian)

- Voluntary Life and AD&D
- Accident
- Cancer
- Critical Illness

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Open Enrollment & Qualifying Events

Open Enrollment Opportunity

Open Enrollment is your opportunity to reevaluate your current benefits and make changes for the coming year. You are given an Open Enrollment opportunity each year during the month of December for a January 1st effective date.

What Changes Can I Make?

. Enroll if not currently on the plan
. Cancel if you have coverage elsewhere
. Add/Drop dependents

Who is Eligible and When:

New full-time employees are eligible for benefits after they have satisfied their waiting period. Eligible employees are effective the first of the month following the date of hire.

If you do not take advantage of this open enrollment opportunity, you must wait until next open enrollment unless you experience a qualifying event that will allow mid-year changes.

What if I forget?

If you don't take advantage of this Open Enrollment opportunity, you cannot enroll or make changes until Open Enrollment next year unless you experience a qualifying event.

PLEASE NOTE: Other than the annual Open Enrollment Period, you cannot make changes to your coverage during the year unless you experience a change in family status, such as:

. Loss of eligibility of a covered dependent
. Death of your covered spouse or child
. Birth or adoption of a child
. Marriage, divorce, or legal separation
. Completion of New hire waiting period
. Loss or gain of coverage through your parent or spouse

You have 30 days from a change in family status to make modifications to your current coverage.

How do I make these changes?

You may contact Callie Ware at (318) 429.0553

HMO Louisiana, Inc.: HMO Copay 80 $1000A

Coverage Period: 1/1/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for: Single or Multi** | **Plan Type: GRP HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bcbsla.com** or by calling **1-800-495-2583**.

Important Questions	Answers	Why This Matters:
What is the **overall deductible**?	For in-network providers: **$1,000** Individual / **$3,000** Family	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event section chart for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event section chart for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. For in-network providers: **$4,000** Individual / **$8,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, Balance Billed Charges, and Health Care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No Maximum Individual/No Maximum Family	The Common Medical Event section chart describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.bcbsla.com or call 1-800-495-2583** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred** or participating for **providers** in their **network**. See the Common Medical Event section chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$50 Copayment	Not covered	If you have a copayment plan, the PCP copayment may be reduced or waived when services are rendered by a Quality Blue Primary Care Provider (QBPC).
	Specialist Visit	$50 Copayment	Not covered	None
	Other practitioner office visit	$50 Copayment	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	Prostate Cancer Screening –One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject

				to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21;
If you have a test	Diagnostic Test (x-ray, blood test)	20% Coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	Not covered	Must obtain authorization.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2017	Tier 1	$10 Copayment	$7 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	$30 Copayment	$30 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2017	Tier 3	$55 Copayment	$70 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 4	10% Coinsurance up to $150 per prescription	10% Coinsurance up to $150 per prescription	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	Not covered	Authorization needed. Failure to do so will result in no benefit.
	Physician/Surgeon Fees	20% Coinsurance after deductible	Not covered	Authorization needed. Failure to do so will result in no benefit.
If you need immediate medical attention	Emergency room services	$350 Copayment	$350 Copayment	Emergency Room Copayment is waived if admitted as in-patient.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you need immediate medical attention	Emergency medical transportation	$50 Copayment	Not covered	None
	Urgent care	$50 Copayment	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	Not covered	Authorization needed.
	Physician/surgeon fees	20% Coinsurance after deductible	Not covered	Authorization needed. Failure to do so will result in no benefit.
If you have mental health, behavioral health or substance abuse needs	Mental/Behavioral health outpatient services	$50 Copayment /office visit and 20% Coinsurance other outpatient services	Not covered	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance after deductible	Not covered	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance after deductible	Not covered	Must obtain authorization
	Substance use disorder outpatient services	$50 Copayment /office visit and 20% Coinsurance other outpatient services	Not covered	May be required to obtain authorization
If you are pregnant	Prenatal and postnatal care	$50 Copayment / pregnancy	Not covered	Covered
	Delivery and all inpatient services	20% Coinsurance after deductible	Not covered	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	Not covered	Must obtain authorization
	Rehabilitation services	20% Coinsurance after deductible	Not covered	None
	Habilitation services	$50 Copayment	Not covered	None

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you need help recovering or have other special health needs	Skilled nursing care	20% Coinsurance after deductible	Not covered	Must obtain authorization
	Durable medical equipment	20% Coinsurance after deductible	Not covered	Prior authorization may be required
	Hospice service	20% Coinsurance after deductible	Not covered	Must obtain authorization
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (Child)
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-495-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Louisiana Department of Insurance 1-800-259-5300 or www.ldi.state.la.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy **does** provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does** meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-495-2583.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next Page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays**: $5,634
- **Patient pays**: $1,906

Sample Care Costs:

Hospital Charges (Mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (Baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, Other Preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$1,000
Co-pays	$62
Co-insurance	$694
Limits Or Exclusions	$150
Total	$1,906

Managing Type 2 Diabetes
Routine maintenance of a well-controlled condition

- **Amount owed to providers**: $5,400
- **Plan pays**: $3,637
- **Patient pays**: $1,763

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other Preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$1,000
Co-pays	$630
Co-insurance	$54
Limits Or Exclusions	$79
Total	$1,763

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition of preexisting condition.
- All services and treatments started and ended in the same period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparison purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.** Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ ຫາກຟຣີ. ຖ້າຫາກຕ້ອງການບໍລິການນັ້ນ,
ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ຫາງຫລັງຂອງບັດປະຈຳຕົວຂອງທ່ານ.
ຖ້າຫາກຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود
کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است
تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

Blue Cross Blue Shield of Louisiana: Blue Saver 100/80 $1900

Coverage Period: 1/1/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for: Single or Multi** | **Plan Type: GRP High**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bcbsla.com** or by calling **1-800-495-2583.**

Important Questions	Answers	Why This Matters:
What is the **overall deductible**?	For in-network providers: **$1,900** Individual / **$3,800** Family	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event section chart for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event section chart for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. For in-network providers: **$1,900** Individual / **$3,800** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, Balance Billed Charges, and Health Care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No Maximum Individual/No Maximum Family	The Common Medical Event section chart describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.bcbsla.com or call 1-800-495-2583** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred** or participating for **providers** in their **network**. See the Common Medical Event section chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-495-2583** or visit us at **www.bcbsla.com**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.bcbsla.com or www.dol.gov/ebsa/healthreform** or call **1-800-495-2583** to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not Applicable	None
	Specialist Visit	No charge after deductible	Not Applicable	None
	Other practitioner office visit	No charge after deductible	Not Applicable	None
	Preventive care/screening/immunization	No charge	Not Applicable	Prostate Cancer Screening –One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject

				to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21;
If you have a test	Diagnostic Test (x-ray, blood test)	No charge after deductible	Not Applicable	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not Applicable	Must obtain authorization.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-2tier-formulary2017	Tier 1	No charge after deductible	Not Applicable	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent.
	Tier 2	20% Coinsurance after deductible	Not Applicable	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent.
	Tier 3	Not Applicable	Not Applicable	
	Tier 4	Not Applicable	Not Applicable	
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Applicable	None
	Physician/Surgeon Fees	No charge after deductible	Not Applicable	None
If you need immediate medical attention	Emergency room services	No charge after deductible	No charge after deductible	None
	Emergency medical transportation	No charge after deductible	Not Applicable	None
	Urgent care	No charge after deductible	Not Applicable	None

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Applicable	Must obtain authorization.
	Physician/surgeon fees	No charge after deductible	Not Applicable	None
If you have mental health, behavioral health or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	Not Applicable	May be required to obtain authorization
	Mental/Behavioral health inpatient services	No charge after deductible	Not Applicable	Must obtain authorization
	Substance use disorder inpatient services	No charge after deductible	Not Applicable	Must obtain authorization
	Substance use disorder outpatient services	No charge after deductible	Not Applicable	May be required to obtain authorization
If you are pregnant	Prenatal and postnatal care	No charge after deductible	Not Applicable	Covered
	Delivery and all inpatient services	No charge after deductible	Not Applicable	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Applicable	Must obtain authorization
	Rehabilitation services	No charge after deductible	Not Applicable	None
	Habilitation services	No charge after deductible	Not Applicable	None
	Skilled nursing care	No charge after deductible	Not Applicable	Must obtain authorization
	Durable medical equipment	No charge after deductible	Not Applicable	Prior authorization may be required
	Hospice service	No charge after deductible	Not Applicable	Must obtain authorization

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-495-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Louisiana Department of Insurance 1-800-259-5300 or www.ldi.state.la.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy **does** provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does** meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-495-2583.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next Page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays**: $5,490
- **Patient pays**: $2,050

Sample Care Costs:

Hospital Charges (Mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (Baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, Other Preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$1,900
Co-pays	$0
Co-insurance	$0
Limits Or Exclusions	$150
Total	$2,050

Managing Type 2 Diabetes
Routine maintenance of a well-controlled condition

- **Amount owed to providers**: $5,400
- **Plan pays**: $3,421
- **Patient pays**: $1,979

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other Preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$1,900
Co-pays	$0
Co-insurance	$0
Limits Or Exclusions	$79
Total	$1,979

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition of preexisting condition.
- All services and treatments started and ended in the same period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparison purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice
Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. **If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.**

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.** Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

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ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ.
ຖ້າທ່ານຫູບໍ່ດີ, ຂໍ ໃຫ້ ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود
کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است
تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

04BA0418 01/17

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, 2016. 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: http://dch.georgia.gov/medicaid - 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.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

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://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: 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://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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 0938-0990

Important Notice from Centenary College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Centenary College 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. **Centenary College has determined that the prescription drug coverage offered by Blue Cross Blue Shield of Louisiana is, on average for all plan participants, expected to payout 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 Centenary College coverage may be affected.

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

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

You should also know that if you drop or lose your current coverage with Centenary College 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 or call Edie Cummings at (318) 869-5191.

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 Centenary College changes. You also may request a copy of this notice at any time.

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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).

[Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]

Medicare Eligible Individual's Name: [Insert Full Name of Medicare Eligible Individual]
Individual's DOB or unique Member ID: [Insert Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]
From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date: [Insert MM/DD/YY]
Name of Entity/Sender: [Insert Name of Entity]

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expiree 1-31-2017)

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 Edie Cummings at 318.869.5191.

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 Centenary College		4. Employer Identification Number (EIN) 72-0408915
5. Employer address P.O. Box 41188		6. Employer phone number 318.869.5191
7. City Shreveport	8. State LA	9. ZIP code 71134
10. Who can we contact about employee health coverage at this job? Edie Cummings		
11. Phone number (if different from above)	12. Email address ecummings@centenary.edu	

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

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

    Employees who work a regular schedule of 30 hours or more per week, have satisfied all of the eligibility requirements, and are in active status.

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouses and dependents of an eligible employee. The employee may cover his or her dependents only if the employee is also covered.

  - ☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth or a 96-hour stay in the case of a Cesarean section.

Benefits for Mothers and Newborns

Hospital Length of Stay

A group health plan or a health insurance issuer offering group health insurance coverage that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn **may not** restrict benefits for the stay to less than the following:

- 48 hours following a vaginal delivery.
- 96 hours following a delivery by Cesarean section.

Delivery in a Hospital

If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

Delivery Outside a Hospital

If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision made by the attending provider.

Exceptions

The prohibitions **do not apply** in the following instances:

- If a decision to discharge a mother earlier than the mandated minimum period is made by an attending provider and in consultation with the mother.
- If a decision to discharge a newborn child earlier than the mandated minimum period is made by an attending provider and in consultation with the mother (or the newborn's authorized representative).

Attending provider means an individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child. As long as the providers are individuals who are licensed under state law, attending providers can be physicians, nurses, and midwives. For the purposes of the NMHPA, a provider is an individual; therefore, hospitals and other care facilities are not included in this definition of an attending provider.

Authorization Not Required

A plan or issuer **may not** require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the minimum required hospital length of stay.

Prohibitions

Mothers

A group health plan and a health insurance issuer offering group health insurance coverage **may not** complete either of the following:

- Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the length-of-stay requirements.
- Provide payments (including payments-in-kind such as baby supplies) or rebates to a mother to encourage her to accept less than the minimum protections available under the length-of-stay requirements.

Benefit Restrictions

A group health plan and a health insurance issuer offering group health insurance coverage **may not** restrict the benefits for any portion of a required hospital length of stay in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

Attending Providers

A group health plan and a health insurance issuer offering group health insurance coverage **may not** — directly or indirectly — complete either of the following:

- Penalize (for example, take disciplinary action against or retaliate against) or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with the act.
- Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with the act, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

Specific Provisions Permitted

The provisions of NMHPA **do not**:

- Require mothers to give birth in a hospital or to stay in the hospital for a fixed period of time, as long as the attending physician and the mother agree to the discharge, as previously described. (Other legal requirements may require this type of coverage, including Title VII of the Civil Rights Act of 1964. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission (EEOC).)
- Require plans or insurers to cover hospital benefits in connection with a pregnancy if the plan does not already do so.
- Prevent plans or insurers from imposing deductibles, co-payments, or other cost-sharing arrangements in connection with hospital stays for maternity, as long as these charges are not greater for longer stays than they are for any earlier portion of a stay.

Required Statement

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Plans subject to state law requirements will need to prepare SPD statements describing any applicable state law.

Pre-Emption of State Law

The NMHPA does not apply with respect to health insurance coverage offered in connection with a group health plan if there is a state law regulating the coverage that meets any of the following criteria:

- The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by Cesarean section.
- The state law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.
- The state law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy this criterion.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)