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CONTACT INFORMATION

Carrier	Benefit	Web Address	Phone Number
EBMS	Medical	www.mibenefits.com	1-866-326-7613
CIGNA	Provider Network	www.mycigna.com	-
ProCare RX	Pharmacy	https://memberaccess.pro-carerx.com	855-828-1484
Guardian	Dental & Vision	www.guardiananytime.com	1-888-482-7342
Guardian	Ancillary Benefits	www.guardiananytime.com	1-888-482-7342
FAIR Health Consumer	Transparency Tool	https://www.fairhealthconsumer.org/medical	1-855-566-5871
Good RX	Pharmacy Pricing	https://www.goodrx.com	855-268-2822

Benefits & Enrollment Contacts	Email Address	Phone Number
Edie Cummings- Director of HR	ecummings@centenary.edu	Direct Line: 318-869-5191 Cell: 318-469-0500
Rachel Thrash- Benefits Group Advisor	rthrash@qnins.com	Direct Line: 318-429-0516 Cell: 318-347-4405
Callie Ware- Benefits Account Advisor	cware@qnins.com	Direct Line: 318-429-0553 Cell: 318-210-1387

MEDICAL: OPTION 1 PLAN HIGHLIGHTS

Insurance Carrier/ Plan Design	EBMS/ PPO Copay
Office Visit Copay	\$50
Urgent Care Copay	\$55
In-Network Deductible- Individual/Family	\$2,000/\$6,000
In-Network Co Insurance	20%
In-Network Individual - Out of Pocket Max	\$6,000
In-Network Family - Out of Pocket Max	\$12,000
Emergency Room Visit	Deductible then 20%
Out of Network Benefits	Refer to SBC

Prescription Drug: Copays	
Tier 1	\$10
Tier 2	\$30
Tier 3	\$55
Tier 4	*Specialty Drugs Not Covered

*Specialty Drugs will no longer be covered on the plan. You will be assigned an advocate to obtain these drugs directly from the manufacturer.

Benefit Tier	Monthly Deduction
Employee	\$175.00
Employee & Spouse	\$490.00
Employee & Child(ren)	\$416.00
Employee & Family	\$612.00

The insurance being offered to you from your employer meets the criteria of affordable and providing minimum essential coverage. You will not be eligible for any subsidy on the Exchange.

If you are at an In-Network Hospital or Emergency Room- The anesthesiologists, pathologists, radiologist and emergency room doctors might not participate in the network. You may be subject to additional billing outside of your deductible. Check with your hospital or doctor in advance of any planned surgery or testing.

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.

MEDICAL: OPTION 2 PLAN HIGHLIGHTS

Insurance Carrier/ Plan Design	EBMS/ PPO HDHP
Preventive Care/Screening/Immunization	No Charge
In-Network Deductible- Individual	\$3,000
In-Network Deductible- Family	\$6,000
In-Network Co Insurance	0%
In-Network Individual - Out of Pocket Max	\$3,000
In-Network Family - Out of Pocket Max	\$6,000
Office Visits for injury or illness	Deductible
Out of Network Benefits	Refer to SBC

This plan is HSA eligible

Prescription Drugs: EE responsibility after medical deductible	
Tier 1	0%
Tier 2	0%

*Specialty Drugs will no longer be covered on the plan. You will be assigned an advocate to obtain these drugs directly from the manufacturer.

Benefit Tier	Monthly Deduction
Employee	\$164.00
Employee & Spouse	\$459.00
Employee & Child(ren)	\$390.00
Employee & Family	\$574.00

The insurance being offered to you from your employer meets the criteria of affordable and providing minimum essential coverage. You will not be eligible for any subsidy on the Exchange.

If you are at an In-Network Hospital or Emergency Room- The anesthesiologists, pathologists, radiologist and emergency room doctors might not participate in the network. You may be subject to additional billing outside of your deductible. Check with your hospital or doctor in advance of any planned surgery or testing.

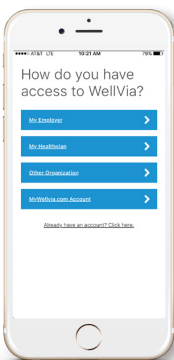
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WELLVIA®

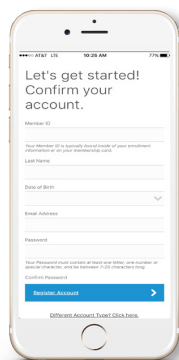
Available
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Talking with
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has never
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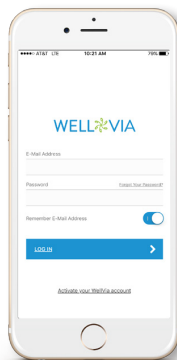
Download the Free WellVia App for Apple and Android Devices!



ACTIVATE



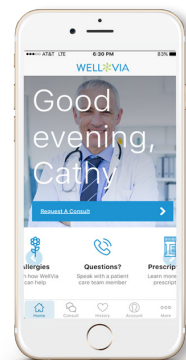
REGISTER



SIGN IN



SECURITY



GET WELL



www.WellViaSolutions.com



Member Care Center: (855) WELLVIA
(855) 935-5842



We have Enhanced Your Prescription Benefit to include FREE Member Portal Access

MC-Rx has built and developed a Member Portal with you in mind. This secure internet site allows you and your dependents access to prescription profiles and other important prescription benefit information. The site can be found by typing the following into the address bar on your internet browser: <https://memberaccess.procarerx.com>



The Member Portal offers the following benefits:

- Create and maintain your own secure login
- Access and/or restrict profile viewing by other family members
- Review your prescription claims history or individual prescriptions
- Look up a drug to identify formulary status and preferred alternatives
- View your year-to-date prescription expenses
- Locate pharmacies within a zip code, state, city, or county
- Refill prescriptions at mail service/transfer prescriptions to mail service
- Participate in clinical programs selected specifically for you
- Print profile reports for historical or tax purposes

855-828-1484

www.MC-Rx.com



Customer Care Center

Have a question? We're just a phone call away!

You can reach us 24 hours a day/7 days a week – we're always available to take your call, even on holidays.

- Locate a network pharmacy
- Understand your pharmacy benefit
- Get prior authorization information



MC-Rx offers convenient home delivery service. Just call your prescription order into us and tell us where to ship it to and we'll take care of the rest.

855-828-1484

DENTAL & VISION PLAN HIGHLIGHTS

Dental Coverage		
Guardian	Deductible (Limit of three)	\$50
	Annual Maximum	\$1,500
	Type 1: Preventive	100%
	Type 2: Basic	90% after deductible
	Type 3: Major	60% after deductible
	Orthodontia (children under 19)	50% after deductible up to lifetime max of \$1500

Benefit Tier	Monthly Deduction
Employee	\$16.19
Employee & Spouse	\$33.52
Employee & Children	\$47.14
Employee & Family	\$63.89

Vision Coverage		
Guardian	In Network Exam Copay	\$10
	In-Network Materials Copay	\$25
	Lenses**	\$0
	Frames**	\$130 Allowance then 20% discount
	Elective Contact Lenses (Includes fitting and evaluation)**	\$130 Allowance then 15% discount
	Frequencies	Exam: Once every 12 months Eyeglass Lenses: Once every 12 months Frames: Once every 12 months Contact Lenses: Once every 12 months

**Benefit Includes coverage for glasses or contact lenses, not both

Benefit Tier	Monthly Deduction
Employee	\$4.57
Employee & Spouse	\$9.13
Employee & Children	\$9.85
Employee & Family	\$14.32

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ANCILLARY PLAN HIGHLIGHTS

Benefits Paid by Centenary

- » Basic Life and AD&D: 1x Annual Salary
- » Dependent Life
- » Long Term Disability
- » Short Term Disability
- » Employee Assistance Program

Employee Paid Benefits

- » Voluntary Life and AD&D
- » Accident
- » Critical Illness incl. Cancer
- » 403(b) Retirement Plan



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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 Edie Cummings at 318-869-5191

How To Submit A Reimbursement Claim (FSA)



All sections of the claim form must be completed in order to receive reimbursement.

Claim Form Section 1: Employee Information

The following information must be included for each claim:

- Employee (Participant) SSN (last 4)
- Employee Name
- Employee Address
- Employee Phone Number

Claim Form Section 2: Claim Information

The following must be included for each claim:

For Medical Expenses

- Date of Service
- Patient Name
- Name of Provider
- Description of Service
- Amount of Claim

For Dependent Care Expenses:

- Date of Service
- Dependent Name
- Dependent Age
- Name of Care Provider
- Care Provider Address
- Provider Tax ID/SSN
- Amount of Claim

For Medical Expenses, you must provide a provider receipt or insurance carrier explanation of benefits (EOB) that contains ALL of the information listed under "For Medical Expenses" above.

Cancelled checks, non-detailed credit card receipts, or generic cash receipts do not provide all the information necessary to substantiate claims and cannot be accepted. Statements with "Previous Balance", "Balance Forward", or "Paid on Account" do not contain all of the necessary information and cannot be accepted.

For Dependent Day Care Expenses, you must provide either a receipt that contains ALL of the information listed under "For Dependent Day Care Expenses" or a signature of the Care Provider on the completed claim form. Expenses submitted for Dependent Care reimbursement must allow the participant to be gainfully employed (or looking for work). Overnight camps, extracurricular activity fees, care for children over the age of 12, and private school fees (for grades Kindergarten and up) are not eligible expenses for Dependent Care reimbursement.

Claim Form Section 3: Signature

The participant must sign and date the claim form in order for the claims to be reimbursed.

For Reimbursement

Submit the claim form by uploading via Summit portal, mobile app, or email.

Summit: qnins.summitfor.me (preferred method)

Summit employer ID: 10 , TPA ID: 84

Email: benefits@qnins.com

Reminders

Carryover Amount: \$ 550

Run-out period to submit 2020 claims: 90 days from 12/31/20 .

Keep all documentation for eligible expenses.

Documentation (substantiation) must be provided for debit card swipes that do not auto-resolve **within 60 days** to avoid card suspension.

2021 claims will use the 2020 carryover first. Keep this in mind if you submit a 2020 claim late in the run-out period. *We can reprocess a 2021 claim to pay a 2020 plan year claim if carryover has been exhausted.*

HEALTH SAVINGS ACCOUNT (HSA)

Employees who are enrolled in CIGNA HDHP option 2 and *elect to participate in the HSA*. Enrollments and account changes can be accomplished online.

Plan Advantages

- HSA contributions, interest and earnings in the account are tax free.
- Contributions to the HSA can be made pre-tax or post-tax and can be changed at anytime.
- There is no “Use It or Lose It” provision. The balance of your HSA account rolls over every year.
- The account is portable if you terminate employment.
- After age 65, the account can be used for other expenses without paying the additional 20% penalty.

Plan Rules

- Account holder must be enrolled in an HSA qualified High Deductible Health Plan (Medical Option 2) and no other health plan.
- HSA should only be used to pay for qualified medical expenses. A 20% penalty tax is applied if money is withdrawn for non-qualified expense.
- The ***maximum contribution limits*** for 2021 are \$3,600 for Employee Only Coverage or \$7,200 for Family Coverage. If you are over 55, you can contribute an additional \$1,000 per year
- You cannot contribute to an HSA if any part of Medicare is elected. However, you can continue to use funds previously contributed.



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.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-326-7018. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-487-2365 to request a copy.

Important Questions		Answers	Why This Matters:
What is the overall <u>deductible</u> ?		Preferred Providers: \$2,000 per plan participant/ \$6,000 per family unit Non-Preferred Providers: \$6,000 per plan participant/ \$12,000 per family unit	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there <u>services</u> covered before you meet your <u>deductible</u> ?		Yes. <u>Preventive care</u> , <u>urgent care</u> and <u>office visits</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and <u>services</u> even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific <u>services</u> ?		No.	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Preferred Providers: \$6,000 per plan participant/ \$12,000 per family unit Non-Preferred Providers: \$12,000 per plan participant/ \$24,000 per family unit	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>services</u> . If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?		Premiums, penalties for failure to pre-certify, <u>balance-billing charges</u> (unless <u>balance billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?		Yes. See www.ebms.com or call 1-866-326-7018 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>non-preferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>preferred provider</u> might use an <u>non-preferred provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?		No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 <u>copayment</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Office visit <u>copayments</u> include x-rays and labs, allergy injections and radiation treatment when billed with an office visit charge. When surgery is performed in the office, it will be payable under the office visit <u>copayment</u> , but no additional services will be payable under the office visit <u>copayment</u> in addition to the surgery. You may have to pay for <u>services</u> that aren't <u>preventive</u> . Ask your <u>provider</u> if the <u>services</u> needed are <u>preventive</u> . Then check what your plan will pay for.
	<u>Specialist</u> visit	\$50 <u>copayment</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required prior to imaging services to avoid a penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Generic drugs (Tier 1)	\$10 <u>copayment</u> /prescription (30-day retail pharmacy)	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ProCareRx.com	Preferred brand drugs (Tier 2)	\$30 <u>copayment</u> /prescription (30-day retail pharmacy)	Not covered	<u>Deductible</u> does apply to <u>prescription drug coverage</u> . Coverage available up to a 90-day supply (retail pharmacy only) at 3 times the 30-day supply <u>copayment</u> . Mail Order is not available.
	Non-preferred brand drugs (Tier 3)	\$55 <u>copayment</u> /prescription (30-day retail pharmacy)	Not covered	
	<u>Specialty</u> drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required prior to outpatient <u>services</u> to avoid a penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance after \$100 copayment/ visit		<u>Emergency Room copayment</u> applies to the facility and physician charges and is waived if admitted.
	<u>Medical emergency</u>	20% coinsurance	50% coinsurance	
	<u>Medical non-emergency</u>			None
	<u>Emergency medical transportation</u>	20% coinsurance		Urgent care visit copayment applies to all services rendered during the visit.
If you have a hospital stay	<u>Urgent care</u>	\$50 copayment /visit; deductible does not apply	50% coinsurance	Pre-certification required prior to inpatient admissions to avoid a penalty.
	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
	Outpatient services	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office visits	\$50 copayment/visit; deductible does not apply	50% coinsurance	Pre-certification required prior to inpatient admissions and outpatient services to avoid a penalty.
	Inpatient services	20% coinsurance	50% coinsurance	
	Office visits	\$50 copayment/visit; deductible does not apply	50% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
If you are pregnant	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Maternity benefits only apply to covered employee or covered spouse.
				Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
you need help covering or have other special health needs	<u>Home health care</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	Pre-certification required prior to <u>home health care</u> to avoid a penalty. Coverage is limited to 60 visits/calendar year.
	<u>Rehabilitation services</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	Outpatient rehabilitation includes physical therapy, speech therapy, and occupational therapy and is limited to combined 60 visits /calendar year. Cardiac and Pulmonary rehabilitation limited to 36 visits per occurrence. Pre-certification required prior to inpatient admissions and outpatient <u>services</u> to avoid a penalty.
	<u>Habilitation services</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	
	<u>Skilled nursing care</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	Pre-certification required prior to <u>skilled nursing care</u> to avoid a penalty. Coverage is limited to 60 days/calendar year.
	<u>Durable medical equipment</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	Pre-certification required prior to <u>durable medical equipment</u> to avoid a penalty.
	<u>Hospice services</u>	<u>20% coinsurance</u>	<u>50% coinsurance</u>	Coverage is limited to 60 visits/calendar year.
your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered
Excluded Services & Other Covered Services:				
services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
Acupuncture		• Infertility treatment		• Routine foot care
Cosmetic surgery		• Long-term care		• Weight loss programs
Dental care (Adult)		• Non-emergency care when traveling outside the U.S.		• Routine eye care (Adult)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)				
Bariatric surgery		• Chiropractic care		• Private-duty nursing
		• Hearing aids		

For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), visit [www.HealthCare.gov](http://www.healthcare.gov) or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](http://www.healthcare.gov) for a denial of a [claim](http://www.healthcare.gov). This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](http://www.healthcare.gov). Your [plan](http://www.healthcare.gov) documents also provide complete information on how to submit a [claim](http://www.healthcare.gov), [appeal](http://www.healthcare.gov), or a grievance for any reason to your [plan](http://www.healthcare.gov). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](http://www.healthcare.gov) generally includes [plans](http://www.healthcare.gov), [health insurance](http://www.healthcare.gov) available through the [Marketplace](http://www.healthcare.gov) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](http://www.healthcare.gov), you may not be eligible for the [premium tax credit](http://www.healthcare.gov).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](http://www.healthcare.gov) doesn't meet the [Minimum Value Standards](http://www.healthcare.gov), you may be eligible for a [premium tax credit](http://www.healthcare.gov) to help you pay for a [plan](http://www.healthcare.gov) through the [Marketplace](http://www.healthcare.gov).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-326-7018.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-326-7018.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-326-7018.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-326-7018.

To see examples of how this [plan](http://www.healthcare.gov) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional services
Childbirth/Delivery Facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$140
Coinsurance	\$2,110
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,310

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	\$2,000
Copayments	\$1,200
Coinsurance	\$480
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,740

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$1,310
Copayments	\$250
Coinsurance	\$240
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-326-7018. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: \$3,000 per plan participant/ \$6,000 per family unit Non-Preferred Providers: \$6,000 per plan participant/ \$12,000 per family unit	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there <u>services</u> covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>urgent care</u> and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and <u>services</u> even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific <u>services</u> ?	No.	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Preferred Providers: \$3,000 per plan participant/ \$6,000 per family unit Non-Preferred Providers: \$6,200 per plan participant/ \$12,400 per family unit <u>Premiums</u> , penalties for failure to pre-certify, <u>balance-billing</u> charges (unless <u>balance billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>services</u> . If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.ebms.com or call 1-866-326-7018 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>non-preferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>preferred provider</u> might use an <u>non-preferred provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Preferred Providers: \$3,000 per <u>plan</u> participant/ \$6,000 per family unit Non-Preferred Providers: \$6,000 per <u>plan</u> participant/ \$12,000 per family unit	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care, <u>urgent care</u> and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Preferred Providers: \$3,000 per <u>plan</u> participant/ \$6,000 per family unit Non-Preferred Providers: \$6,200 per <u>plan</u> participant/ \$12,400 per family unit <u>Premiums</u> , penalties for failure to pre-certify, <u>balance-billing</u> charges (unless <u>balance billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.ebms.com or call 1-866-326-7018 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>non-preferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>preferred provider</u> might use an <u>non-preferred provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Acupuncture	• Infertility treatment	• Routine foot care	
• Cosmetic surgery	• Long-term care	• Weight loss programs	
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Bariatric surgery	• Chiropractic care	• Private-duty nursing	
	• Hearing aids		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-326-7018.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-326-7018.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-326-7018.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-326-7018.

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

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* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional services
Childbirth/Delivery Facility services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,940
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,000

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$520
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,580

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

WHCRA Notice: The Women's Health and Cancer Rights Act of 1998

As specified in the Women's Health and Cancer Rights Act, if you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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.

Notice: Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in your group's health plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to the first day of first plan year beginning on or after September 23, 2010. For more information contact Querbes & Nelson at 318.429.0553.

Notice: Lifetime Limit No Longer Applies

The lifetime limit on the dollar value of benefits under your company no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Querbes & Nelson at 318.429.0553.

Patient Protection Notice

Designation of Primary Care Providers

You have the right to designate any primary provider (PCP) who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as a PCP.

Direct Access to OB/Gyns

You do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Newborns' And Mothers' Health Protection Act Notice

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

COBRA Coverage Notice

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end as a result of certain events defined under federal law (known as qualifying events).

Qualified beneficiaries are entitled to elect COBRA when a qualifying event occurs, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for coverage at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce or legal separation, or a child ceasing to be an eligible dependent. The maximum period of COBRA continuation coverage is generally either 18 or 36 months, depending on the qualifying event.

For questions regarding any of the above notices, including Medicare Part D, WHCRA or COBRA, or to request special enrollment or obtain additional information, please contact Human Resources.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 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 of Louisiana		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:

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

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

The spouse and dependent(s) of an eligible employee. The employee may cover his or her dependent(s) 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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? \$ 164.00

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)

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Centenary College of Louisiana 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 of Louisiana 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 of Louisiana has determined that the prescription drug coverage offered by ProCare RX is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
-

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Centenary College of Louisiana coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Centenary College of Louisiana coverage, be aware that you and your dependents will 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 of Louisiana 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 Edie Cummings at 318-869-5191 for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Centenary College of Louisiana changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/30/2020
Name of Entity/Sender: Centenary College of Louisiana
Contact--Position/Office: Edie Cummings
Address: P.O. Box 41188, Shreveport, LA 71134
Phone Number: 318-869-5191

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

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

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

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

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

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

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAUCONT.aspx Phone: 916-440-5676
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	MINNESOTA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	NEBRASKA – 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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	TEXAS – Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	VIRGINIA – Medicaid and CHIP Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	WEST VIRGINIA – Medicaid Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP Website: http://www.cohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	WISCONSIN–Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

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

Your Choices

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

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at [contact info] .
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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

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

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

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

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

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

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SHREVEPORT, LA 71101
318.221.5241