



Empower Results®

Hope College



Newborns' and Mothers' Health Protection Act

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).

Women's Health and Cancer Rights Act of 1998

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient.

Call your HR Department for more information.

Your HIPAA Privacy Rights

Keeping your personal health information private is your right. That's why the U.S. government passed the "Privacy Rule" – part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule, passed in 2003, protects your health information and makes it illegal for health care providers to reveal information about your health without your permission unless needed to treat your condition. It also prevents the improper use of health information by health care benefit insurers and administrators. Doctors' offices and health care facilities are required by law to obtain your written permission to appropriately reveal information about your health.

A copy of our Notice of Privacy Practices is available upon your request.

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.

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



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 August 11, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.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@MyAKHIP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x	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	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP P Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075



NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	WEST VIRGINIA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	WYOMING – Medicaid
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since August 11, 2019, 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



Patient Protection Model Disclosure

BCBSM generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSM.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCBSM or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBSM.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31-days, your Plan participation will not be interrupted. If the absence is for more than 31-days and not more than 12-weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31-days, or if you revoke a prior election to continue to participate for up to 12-weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

GINA Notice

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Important Notice from Hope 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 **Hope 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. Hope College has determined that the prescription drug coverage offered by the Hope College 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 and drop your Hope College prescription drug coverage, be aware that **your current prescription drug coverage is part of your medical coverage from Hope College. You cannot drop your Hope College prescription drug coverage unless you also drop your Hope College medical coverage.** If you enroll in a Medicare Part D plan and drop your creditable coverage with Hope College, you may not be able to return to the same plan through Hope College until the next enrollment period.

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

You should also know that if you drop or lose your current coverage with Hope 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 your local Human Resources Department. **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 Hope College 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: August 11, 2019
Name of Entity/Sender: Connie VanderZwaag
Contact--Position/Office: Human Resources
Address: 100 East 8th Street Suite 210
Holland, MI 49423
Phone Number: 61-395-7818

Hope College Group Health Plan Procedures for Handling Medical Child Support Orders

1. The plan administrator will designate a responsible individual, by name, title or both, to receive all medical child support orders (MCSOs) delivered to Hope College.
2. Employees who could receive the MCSOs will be instructed to deliver any medical child support order, and any domestic relations order which purports to be a medical child support order, to the individual designated for this purpose. The immediate delivery of any such order to the designated individual is absolutely necessary in order to minimize potential fiduciary liabilities for failing to act prudently as required by ERISA, including liabilities for uncovered medical expenses.
3. Upon receipt of a MCSO, the designated individual will:
 - (a) Forward a copy of the MCSO and related correspondence to the plan administrator or its designated representative to determine if the MCSO is a qualified MCSO (“QMCSO”); and
 - (b) Promptly notify the effected employee and each alternate recipient of (1) the receipt of the MCSO, (2) the plan’s procedures for determining whether the MCSO is a QMCSO, and (3) the alternate recipient’s right to designate a representative for the receipt of copies of notices to be sent to the alternate recipient with respect to the MCSO. If the alternate recipient is a minor, the notice will be sent in care of the custodial parent or legal guardian identified in the order.
4. If the MCSO is a National Medical Support Notice (as defined in ERISA Section 609(a)(5)(c)), the designated individual will notify the issuing agency, within 20 business days of the date of the notice, if the employee is not eligible for coverage under the plan or if state or federal withholding limitations prevent the withholding from the employee’s income of the amount required to obtain coverage under the terms of the plan. (In which case, no coverage will be provided to the proposed alternate recipient).
5. Within a reasonable time after receipt of the MCSO, the designated individual, or legal counsel on his or her behalf, will review the MCSO and make a determination as to whether the MCSO meets all of the requirements for a QMCSO under ERISA. (See the Plan Administrator’s QMCSO Determination Checklist for the factors to be used to determine the MCSO’s status).
6. If the MCSO is a National Medical Support Notice, the notice will be deemed to be a QMCSO if it contains the name of the issuing agency, the name and mailing address of an employee who is participating under the plan, the name and mailing address of the alternate recipient(s) (or name and address of the official or agency which has been substituted for the mailing address of the alternate recipients) and identifies an underlying child support order. The designated individual, or legal counsel on his or her behalf, will determine whether the notice complies with the requirements of this paragraph.
7. The responsible individual, or legal counsel on his or her behalf, will notify the employee and each alternate recipient (or his/her designated representative or the issuing agency), in writing, of the determination as to the qualification of the MCSO as a QMCSO within a reasonable period of time after receipt of the order but not later than 40 business days after the date of the notice with respect to a National Medical Support Notice.
8. If the MCSO fails to meet the requirement for a QMCSO, the notice described in 7 above will include an explanation of the deficiency. If the MCSO is a National Medical Support Notice, the designated individual will complete item 5 of the plan administrator response, sign the response and send it to the issuing agency.

9. If the MCSO is, or ultimately becomes, a QMCSO, the designated individual will (1) determine the coverage and benefit options available, if any, to the alternate recipient in accordance with these procedures, and (2) deliver applicable enrollment forms, plus filing instructions, a copy of the plan's current summary plan description, including any applicable summary of material modifications and benefit booklets or other benefit descriptions not included in the summary plan description or summary of material modifications, to each alternate recipient identified in the QMCSO or to his/her designated representative or the issuing agency.
10. If the QMCSO is a National Medical Support Notice, the plan administrator will notify the issuing agency, within 40 business days of the date of the notice, of the alternate recipient's eligibility for coverage, the effective date of coverage and, if necessary, the steps to be taken by the custodial parent or agency to obtain coverage for the alternate recipient. If the custodial parent must take any steps to obtain coverage, the plan administrator will provide a copy of the plan's current summary plan description, applicable enrollment forms and filing instructions to the custodial parent.
11. Coverage will be offered to the alternate recipient in accordance with the plan's terms as follows:
 - (a) If the employee is covered under the plan with family coverage, the alternate recipient will only be offered coverage in that same coverage option. However, the plan administrator should have the alternate recipient complete the plan's enrollment form. The enrollment form should be sent to the alternate recipient with the coverage option box selected and a cover letter should also be sent explaining that the alternate recipient may only receive coverage under the employee's existing coverage option, but that the other portions of the enrollment form need to be completed before the alternate recipient is covered under the plan.
 - (b) If the employee is receiving coverage under the plan, but the alternate recipient lives outside the network or HMO coverage area of the employee's coverage option, the plan administrator will allow the employee to elect a different option that will cover the alternate recipient. If the employee does not make a timely election, the custodial parent (or authorized issuing agency) may elect the coverage option and the employee's coverage will be changed to the option so elected.
 - (c) If the employee is not receiving coverage under the plan, the plan administrator will allow the employee to elect the coverage option that will apply to both the employee and the alternate recipient. If the employee does not elect a coverage option in a timely fashion, the alternate recipient's custodial parent (or issuing agency, in the case of a national medical support notice) may elect the coverage option. The employee will be required to be covered under the plan when the alternate recipient's coverage begins. **If the plan administrator does not hear from the alternate recipient's custodial parent or authorized issuing agency within 20 business days of the date the notice is sent to the alternate recipient's custodial parent or the issuing agency, the alternate recipient (and employee) will be enrolled in BCBSM.**
12. Upon receipt of fully completed enrollment forms, the plan administrator will enroll each alternate recipient as an eligible dependent of the employee in the plan in the coverage option available to the alternate recipient as determined in paragraph 11. The alternate recipient's coverage will be effective on the first day of the calendar month coincident with or following the receipt by the plan administrator of such fully completed enrollment forms. The alternate recipient is not entitled to coverage or any type or form of benefit, or any option, not otherwise offered by the plan. However, the alternate recipient is entitled to options such as dental and vision, if offered by the plan, even though the employee only has major medical coverage, if the employee is eligible for such coverage, and if the QMCSO states the alternate recipient is to have such coverage.

13. Effective as of the date the alternate recipient's coverage commences under the plan, the plan administrator may take any necessary steps to collect any applicable premium for the alternate recipient's coverage which the employee is required to pay pursuant either to the terms and conditions of the QMCSO or the terms and conditions of the plan. The means of collection may include, but is not limited to, pre-tax or post-tax payroll deductions.
14. Any claims submitted to the plan administrator for medical expenses incurred prior to the effective date of the alternate recipient's coverage under the plan will not be considered as eligible expenses and no payment or other reimbursements will be made for such expenses by the plan.
15. Any payment of plan benefits in reimbursement of eligible expenses paid by an alternate recipient, or by an alternate recipient's custodial parent or legal guardian on his/her behalf, will be made to the alternate recipient or to the applicable custodial parent or legal guardian.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Hope College		4. Employer Identification Number (EIN) 38-1381271	
5. Employer address 100 East 8 th St Suite 210		6. Employer phone number 616-395-7818	
7. City Holland	8. State MI	9. ZIP code 49423	
10. Who can we contact about employee health coverage at this job? Connie VanderZwaag			
11. Phone number (if different from above)		12. Email address	

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

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

- Some employees. Eligible employees are:

Employees who are scheduled to work at 1,560 hours per year

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

Spouse, and your dependent children who are under the age 26, including natural child, stepchild, a legally adopted child, child placed for adoption or child for whom you or your spouse are the legal guardian; or unmarried child age 26 or over who is or becomes disabled and dependent upon you.

- 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.

• 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)