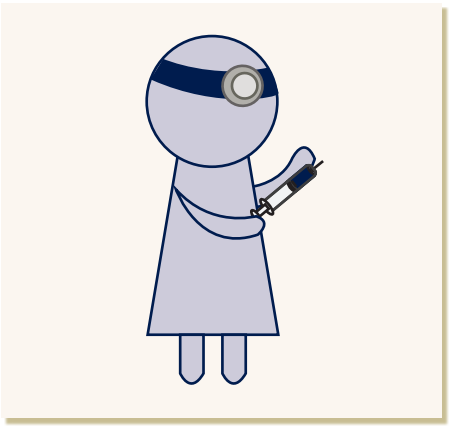
Your Henderson Brothers guide to enrolling in

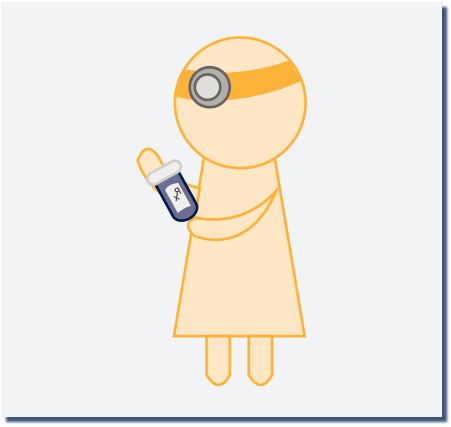
INDIVIDUAL HEALTH COVERAGE

LEARN THE BASICS

KNOW YOUR OPTIONS



COMPARE THE COSTS



CHOOSE YOUR COVERAGE

HENDERSON BROTHERS®

Confused by your coverage options?

Health insurance is important. It's also complicated.

Between looking up all of the different health plans and wrangling with complex legislation, educating yourself can take a lot of time you'd rather spend doing something else.

This year, Henderson Brothers did some of the legwork for you. We've collected information from all of our best sources and broken down the basics, starting with how your coverage works all the way to a glossary in the back of this booklet that defines common insurance terms that you might be unfamiliar with.

THREE BIG FACTORS

AFFECTING WHAT YOU PAY FOR HEALTH CARE

PREMIUM

Your premium is the monthly payment that you make for health insurance.

This payment can increase each year because of your age, medical inflation, insurance taxes, the insurer's medical loss ratio, or new regulatory obligations.

Your **deductible** will affect the size of your premium. Plans with higher deductibles will often have lower premiums, while plans with lower deductibles generally have higher premiums.

DEDUCTIBLE

Your deductible is the set dollar amount you must spend on certain health care services before your insurance will cover them.

If you have a large monthly **premium**, you will probably have a smaller deductible. If your plan has a less pricy premium, this means that you will likely be responsible for a bigger deductible.

Any payments that you have made towards your deductible will also count towards your **out-of-pocket maximum**.

OUT-OF-POCKET MAXIMUM

Your out-of-pocket maximum is the yearly limit on what you pay for covered services.

When you have reached your out-of-pocket maximum, your plan will cover 100% of eligible **in-network** health care services that you recieve.

This amount includes payments made toward your deductible, as well as money spent on **coinsurance** and **copayments**.

YOUR PLAN RENEWS & BENEFITS RESET ON JANUARY 1ST

No matter when you bought your plan during the year, your policy typically renews every year on January 1st. When your policy renews, it's common to see an increase in the premium.

Benefits (such as deductibles, coinsurance caps, and other limits or maximums) will also reset. This means that if you satisfied a $500 deductible during the plan year, it will reset to $0.

Check with your insurer to find out exactly when your premium will change and your benefits will reset each year.

Your plan covers many **preventive services**, such as physical exams and vaccinations, at no cost to you when you see an **in-network** provider. Refer to your insurer's preventive schedule for frequency limits and other important details. With the exception of covered preventive services, you pay 100% of health services you use until you meet your deductible.

YOU PAY
100%
+copayments, coinsurance, and premium

Do you know how your health plan works throughout the year?

Get to know the impact that your premium, deductible, and out-of-pocket maximum have on the amount of money that you are spending on health care.

YOU MEET YOUR DEDUCTIBLE

Now your plan covers the majority of eligible services. For example, your insurer may pay 90% of the cost while you will only pay 10% coinsurance. You will still be responsible for your coinsurance and copayments until your out-of-pocket maximum is met.

YOU PAY
10%
+copayments, coinsurance, and premium

YOU REACH YOUR OUT-OF-POCKET MAXIMUM

Your plan covers 100% of all covered services from **in-network** providers.

YOU PAY
0%
+premium

Shop Smart: Choosing the right deductible

Considering how often you use coverage may help you lower health care costs.

If you don't visit the doctor often or take expensive medicine, you may want to look at plans with higher deductibles, coinsurance, and copays, as these plans will generally have a lower premium. A higher deductible means you'll pay more for services when you use them, but you can save money on monthly cost.

But if you do use your plan frequently, then you might want to consider a lower deductible and less out-of-pocket cost. While you will pay more monthly, you can save money on health services such as doctor's appointments or prescription drugs.

When can you get coverage?

During Open Enrollment

Open enrollment for 2016 is November 1, 2015 through January 31, 2016. After January 31, 2016, you can enroll in a 2015 health insurance plan only if you have a life event that qualifies you for a Special Enrollment Period.

During a Special Enrollment Period

Life events that may qualify you for a Special Enrollment Period include:

- Getting married.
- Having a baby.
- Adopting a child or placing a child for adoption or foster care.
- Moving to a new residence.
- Gaining citizenship or lawful presence in the U.S.
- Leaving incarceration.

You may also qualify if you lose your health coverage. Some examples that qualify you for a Special Enrollment Period are:

- Losing job-based coverage for any reason:
  - Your employer stops offering coverage.
  - You leave your job by choice.
  - You get laid off or fired.
  - You choose not to re-enroll in a job-based plan when its plan year ends.
- Your job-based plan not meeting the definition of affordable or minimum value, and as a result you become newly eligible for a premium tax credit.
- Losing coverage through a divorce.
- COBRA coverage ending.
- Turning 26 and losing coverage under a parent's plan.
- Losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP), which includes your child aging off CHIP.
- For people already enrolled in Marketplace coverage, a change in income or household status affecting eligibility for premium tax credits or cost-sharing reductions.

You will not qualify for a Special Enrollment Period if you:

- Voluntarily drop job-based coverage before the year ends.
- Voluntarily quitting a Marketplace plan mid-year.
- Cancel COBRA before it ends.
- Lose coverage because you didn't pay your premium.

Where can you purchase insurance?

Through a broker

One way to purchase coverage is through a broker, such as Henderson Brothers.

When you buy health care through Henderson Brothers, your consultant will help you weigh the plans offered by Highmark, UnitedHealthOne, CoventryOne, and UPMC Health Plan to find the coverage option that best suits your needs.

From a private insurer

It's also possible to buy your coverage directly from a private insurer. In this case, you would contact either Highmark, UPMC, UnitedHealthOne, or HealthAmerica and speak with an agent who could advise you on plans and sell you coverage.

On the Federal or State Exchange Marketplace

It's important to note that purchasing through the Federal or State Exchange Marketplace will limit your options, because it only offers plans from a few insurers. If you buy coverage from the Marketplace, you may be eligible for federal financial assistance such as **Advanced Premium Tax Credits** and **Cost-Sharing Reductions**.

Healthcare.gov offers tools to help you determine your eligibility based on household income. You can get more information on Exchanges by calling 1-800-318-2596 toll-free to help you choose a plan, determine eligibility for federal subsidies or Medicaid/CHIP, rate plans based on quality and price, and conduct outreach and education.

Advanced Premium Tax Credits

Family Size	2015 Income
Individual	$11,670 - $46,680
Family of two	$15,730 - $62,920
Family of three	$19,790 - $79,160
Family of four	$23,850 - $95,400
Family of five	$27,910 - $111,640
Family of six	$31,970 - $127,880

Cost-Sharing Reductions

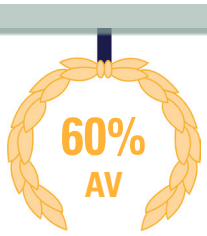
Family Size	2015 Income
Individual	$11,670 - $29,175
Family of two	$15,730 - $39,325
Family of three	$19,790 - $49,475
Family of four	$23,850 - $59,625
Family of five	$27,910 - $69,775
Family of six	$31,970 - $79,925

Comparing plans: Cost and coverage

Qualified health plans are organized into four metal levels: bronze, silver, gold, and platinum.

Looking at a plan's metal level will typically give you a general idea of its overall cost to you, such as whether it has a high premium and how much money you would spend out-of-pocket on prescriptions and health care services. This is measured by a plan's Actuarial Value (AV), or the expected medical costs a health plan will generally cover.

Bronze



What are the costs?

Bronze plans have the lowest premiums and highest out-of-pocket spending limits.

Is this type of plan right for me?

Bronze level coverage is a good option if you don't use health care services often and are comfortable incurring higher out-of-pocket costs should the need for medical care arise.

Silver

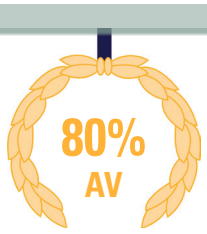
What are the costs?

Silver plans have lower premiums and moderate out-of-pocket spending limits.

Is this type of plan right for me?

Consider silver coverage if you want to balance costs between your monthly premium and health care charges.

Gold



What are the costs?

Gold plans usually have moderate premiums as well as lower out-of-pocket spending limits.

Is this type of plan right for me?

Gold coverage is good if you don't mind spending more money monthly to keep costs lower when using health services.

Platinum

What are the costs?

Platinum plans have the highest premiums and lowest out-of-pocket spending limits.

Is this type of plan right for me?

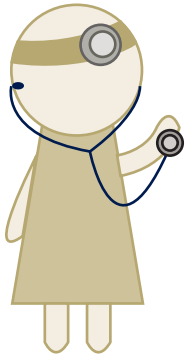
Platinum level coverage is a good option if you use health care services very frequently and are comfortable paying a higher monthly premium in exchange for lower out of pocket costs.

Is your doctor covered under your plan?

Not all carriers will cover the services you receive from your current doctor. Providers your insurance carrier considers to be in-network depends on the type of plan you choose.

Plans generally offer a higher level of coverage for services from **in-network** providers—doctors and hospitals contracted with your insurer to provide health services to members. Plans may also offer **out-of-network** services at a higher cost to you.

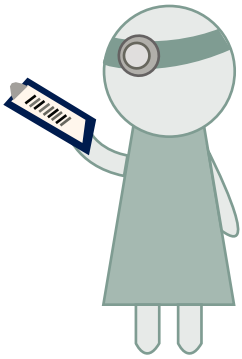
Familiarize yourself with the different catagories and how they could affect you.



Health Maintenance Organization

A Health Maintenance Organization (HMO) plan covers services from health care providers who are employed by or under contract with the plan. Be certain you're comfortable with the list of covered medical providers, because HMOs don't cover services from out-of-network health care providers, except in cases requiring **emergent care**.

Under an HMO, you'll need to select a Primary Care Physician (PCP) and have a referral from your PCP in order to see a specialist.



Exclusive Provider Organization

Exclusive Provider Organization (EPO) plans are very similar to HMO plans, except that EPO plans generally don't employ their own doctors or require referrels. The same out-of-network coverage conditions apply.

Preferred Provider Organization

Under a Preferred Provider Organization (PPO) plan, an insurer and its health care provider network can offer substantial discounts to covered health services, as well as lower copays and deductibles, for in-network services. For example, the plan's payment ratio could be 90/10, which means the insurance company pays 90% of medical costs and you pay 10% (after the copay and deductible).

No referrals are necessary and out-of-network benefits are available.

Funding your Health Savings Account

A **health savings account** (HSA) can be funded with tax-exempt dollars to help pay for eligible out of pocket medical expenses (including deductible, coinsurance, and in some cases, premium).

A HSA may be used to pay for out-of-pocket expenses that aren't covered by your plan, or to save your money for future medical costs. A HSA can be set up through your personal bank or another bank in your area.

How much money can you put in your HSA?

The amount you can contribute to your HSA changes every year:

2015 annual contribution limits

Individuals* with family coverage:	$3,350
Individuals* with self-only coverage:	$6,650

*Add $1,000 for individuals over 55 years old

Determine your HSA eligibility

In order to qualify for a HSA, you should be covered by a consumer-driven high deductible health plan (HDHP). If you are covered by more than one plan, all additional coverage must also be consumer-driven HDHPs.

You are ineligible for a HSA if:

- You are covered by a non-consumer-driven HDHP (e.g. traditional medical plan or some FSAs)
- You are enrolled in any type of Medicare benefits (including Part A)

Is your plan a consumer-driven HDHP?

Consumer-driven HDHPs are often referred to as "HSA Qualified Plans", "Qualified High Deductible Health Plans", "HSA Plans". If you open up an HSA, please make sure that your High Deductible Health Coverage meets the qualifications for HSA participation. These plans are defined by minimum annual deductible, maximum out-of-pocket expenses, and how the deductible performs when services are incurred:

2015 consumer-driven HDHPs

Family coverage	
Minimum annual deductible:	$2,600
Maximum out-of-pocket*:	$12,900

Self-only coverage	
Minimum annual deductible:	$1,300
Maximum out-of-pocket*:	$6,450

*Out-of-pocket expenses don't include premiums

Terms to know

Advanced Premium Tax Credits

A new tax credit to help you afford coverage purchased through the Marketplace, which can be used right away to lower your monthly premium costs. Premium tax credits can be applied to coverage in any metal level. If you qualify, you may choose how much credit to apply to your premiums each month, up to a certain amount. If your advance payments for the year are less than the credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments are more than the amount of your credit, you must repay the excess with your tax return.

Coinsurance

Payment for services after you've met your deductible. You are usually required to pay a specified percentage of charges.

Copayment

Arrangement where you pay a specified amount for health care services and your plan pays the remainder.

Cost-Sharing Reductions

A form of financial assistance available to Marketplace enrollees, which work by reducing a person or family's out-of-pocket cost when they use health care services. Cost-sharing subsidies can only be applied toward a silver plan. Essentially, the cost-sharing subsidy increases the actuarial value of a silver plan, in some cases making it similar to a gold or platinum plan.

Deductible

The set dollar amount you must spend on certain health care services before your insurance will cover them.

Dependent

Any individual, adult or minor covered by the insurance plan of a parent, relative, or other person.

Terms to know

Emergent care	Care required in case of an immediate risk to life or threat of grave disability.
In-network	Providers such as doctors and hospitals that your insurer has contracted with to provide health services to members.
Out-of-pocket maximum	The yearly limit on what you pay for covered services.
Out-of-network	Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan to provide services to its members. Depending on the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
Premium	The monthly payment you make for health insurance.
Preventive services	Any medical checkup, test, immunization, or counseling service used to prevent chronic illnesses from occurring.
Qualified health plan	An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.