VIA BENEFITS™

2020 Health Insurance Enrollment Guide

Guide to Enrolling in Individual & Family Plans Through Via Benefits

Lubrizol

A Simpler Way to Shop for a Health Plan

Via Benefits Insurance Services helps you shop for and enroll in a health plan. You can browse plans in our online marketplace, call us for help, or do a little bit of both. Our goal is to help you find a health plan that works for you and your household. This guide outlines the services we offer and the information you need when shopping for a plan. Please note, our services are free to you—there is no cost or commitment on your part. We look forward to helping you choose health coverage that works for you and your family!

Quick guide: Steps to enrollment

Prepare

- ❍ Create an online account (page 4)
- ❍ Schedule a call to enroll with a licensed benefit advisor (page 5)
- ❍ Estimate your household income for the coming year (page 7)
- ❍ See if you can lower your costs (page 8)
- ❍ List health care services you currently use (page 10)
- ❍ Review available health plans (page 11)

Enroll

- ❍ Collect your documents and call Via Benefits (page 13)
- ❍ After you enroll (page 14)

How to contact us

marketplace.viabenefits.com/lubrizol

Or call us!

1-866-356-8150
(TTY: 711)

Monday through Friday
8:00 a.m. until 9:00 p.m. Eastern Time

Lubrizol
ACC-EG-2020

Via Benefits Is Your Resource

Via Benefits is a full service health insurance marketplace combined with personalized, unbiased support. We offer a selection of plans from the nation's largest carriers along with assistance from our licensed benefit advisors to help you find and select a health plan that fits the needs of you and your family. Via Benefits offers plans from both the public marketplace and directly from private insurance companies.

How we can help you

Health insurance is complicated. It can be difficult trying to figure out which medical plan is best for your situation. Via Benefits is here to help you and make sense of your coverage choices.

Whether you choose to purchase coverage through the public marketplace or directly from a private insurer may depend on whether you qualify for lower-cost coverage options, including tax credits that can be used to lower the monthly cost of your health insurance. If you are interested in determining if you qualify for a tax credit, we can help. If you qualify, you must purchase your insurance through a public marketplace to make use of the tax credit, and we can help you do that, too.

We encourage you to schedule a call with a Via Benefits licensed benefit advisor. Scheduling a call is important because it gives you the time to ask questions and get the necessary information to make your decision. You can schedule your call by phone, or you can schedule it online once you have created an account with Via Benefits. A licensed benefit advisor will help you with all the details, guide you step by step, and answer questions such as:

- Can I lower my costs?
- How do I know which plan to choose?
- What do all these terms mean?
- Which forms do I need to fill out?

You can access our privacy policy at my.viabenefits.com/about/privacy-policy. If you have questions or concerns about our privacy policy, please contact us at my.viabenefits.com/help.

We'll work together

When you call to enroll, a licensed benefit advisor will ask for information about your income and health care needs. This information is essential to help you find the plan that fits your unique requirements and budget.

Your information is private. We will use it only as required by law to help you enroll in a plan.

We don't try to steer you into one insurance plan or another, because we work for you. What matters to us is that you and your family are matched with the right plan. How much a plan costs and what it offers can vary a lot across insurance companies. We'll help you figure it out.

After you enroll in your new health plan you'll be able to continue to call on us at any time. If you move, get married, have a baby, or simply have a question—just give us a call. Our contact information is on the inside back cover of this guide.

What you can do now

Let's get started! There are two important things you can do right away: create an account online and schedule a call to enroll.

Create an account online

To reduce the time you spend on the phone during the enrollment process, you can create an account online and update your household details. Simply go to the Via Benefits website and click the **Create an Account** button under the **First-time Visitor?** section.

On our website, you'll find easy-to-use tools, frequently asked questions, and information to help you to find a plan that meets your needs. (See page 13 for details.) In most cases, you will also be able to browse specific plans in your area, check your availability for tax credits, and begin enrollment.

Schedule a call to enroll

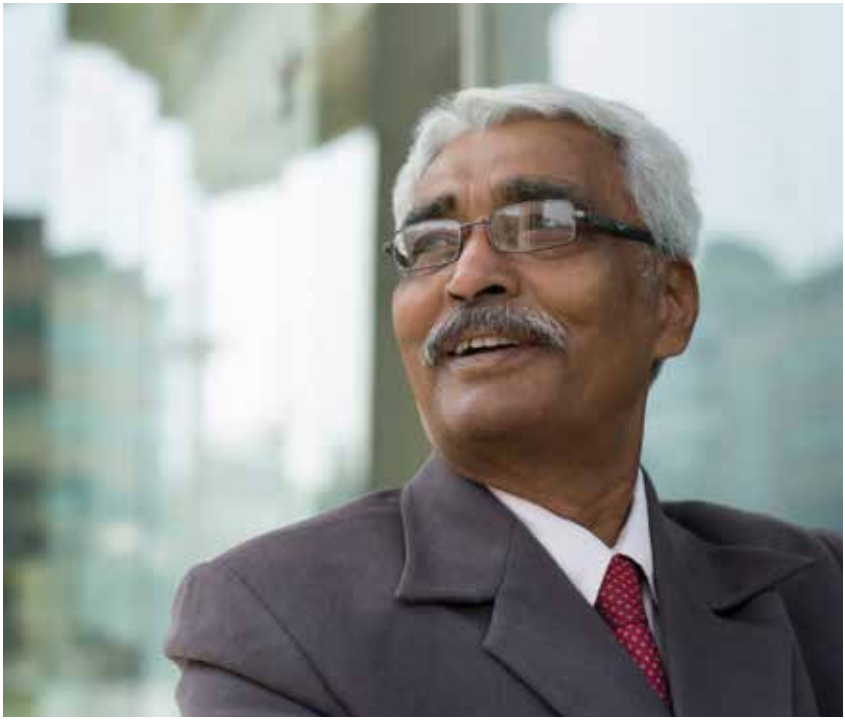
Schedule a call to speak with a licensed benefit advisor as soon as possible. You can schedule a call online, or call the phone number printed at the bottom of every even page in this guide. We will match you with a licensed benefit advisor who is trained to speak with you about the plans available in the state in which you reside.

Allocate 90 minutes for your call if you're enrolling in a plan just for yourself. If you wish, you can complete this process in more than one call.

This may seem like a lot of time, but you'll need it because:

- Your situation is unique—you'll need to discuss your budget, how you will use your health plan, and what benefits are important to you
- We won't rush you through the process

For security purposes, your licensed benefit advisor will need to confirm your personal information before you start to search for a plan.



The Enrollment Process

Now that you've learned a little more about how Via Benefits can help you, you're ready to move to the next step toward enrolling in a health plan: defining your needs.

To make the process easier and quicker, you'll want to do some advance preparation.

Identifying what you may need for next year

After you've scheduled a call to enroll, we recommend you follow these four steps to help you think about what you and your family may need.

1. Estimate your household income for the coming year
2. Determine if you can lower your costs
3. Identify the health care services you currently use
4. Review available health plans

We'll review each of these steps in the coming pages.

1 ESTIMATE YOUR HOUSEHOLD INCOME

Estimating your household income is the first step in determining if you can lower your costs. People have different work situations, and earn income from different places. Maybe you:

- Work part-time
- Collect Social Security
- Have more than one job
- Sell things on eBay
- Get child support or alimony
- Earn tips from customers

One of the easiest ways of figuring out what your income will be next year is to look at last year's tax return. A fair estimate can be arrived at by taking last year's adjusted gross income and then taking into account any changes you anticipate in the coming year. If you have your tax return ready when you speak with us, that will help with the discussion.

2 SEE IF YOU CAN LOWER YOUR COSTS

Depending on your income level, you may qualify for an Advanced Premium Tax Credit (APTC) or the Cost Sharing Reduction (CSR) program.

The following table outlines the annual income levels required to qualify for a an APTC or CSR program in 2019. (Incomes that qualify are higher in Alaska and Hawaii.)

- Between $12,490 - $49,960 for individuals
- Up to $67,640 for a family of two
- Up to $85,320 for a family of three
- Up to $103,000 for a family of four
- Up to $120,680 for a family of five
- Up to $138,360 for a family of six

If your income is lower than these thresholds, you may be eligible for Medicaid or the Children's Health Insurance Program (CHIP) for your children. See the next page for more information.

If your income is higher than these thresholds, you will probably not qualify for an APTC or CSR program.

Financial Assistance for Health Insurance

Advanced Premium Tax Credit (APTC)	▪ Lowers the cost of your premium ▪ Based on both household income and family size ▪ Paid by the government directly to your health insurance company
Cost Sharing Reduction (CSR)	▪ The health insurance plan pays a higher percentage of costs for covered medical services for people with lower income levels. People who are eligible for CSR can get additional savings, in the form of lower out-of-pocket costs, when they select health plans from the Silver category.
Medicaid and Children's Health Insurance Program (CHIP)	▪ Provides free or very low-cost care to adults and/or children in low-income families ▪ If you qualify, you will be directed to your state Medicaid or CHIP office to enroll

For more information about these APTCs and CSR programs, speak with a licensed benefit advisor at Via Benefits.

3 LIST CURRENT HEALTH CARE SERVICES

The type of health plan you need may depend on the frequency of use and what type of health care you are currently using. Some people only see the doctor for an annual physical and the occasional flu, while others need to use services for chronic conditions, multiple prescriptions, and other circumstances.

If you have specific needs, write them down before your scheduled call. Take a moment to list the names of your primary care physician and other health care professionals you use often. If you take prescription medications, write down all prescriptions you have—including name, dosages, and frequency. Your licensed benefit advisor can check to see if the plans in your area include your current doctor and how the plan covers prescriptions.

Make sure you do this for each member of your household.

A couple of other things to think about that could affect the type of plan you choose:

- Do you spend time in another part of the country or travel often?
- How much can you afford to spend on out-of-pocket costs throughout the year?

4 REVIEW HEALTH PLANS

Health plans are categorized into different levels based on how much you pay for premiums and out-of-pocket costs. The chart describes the differences between the four plan levels.

The three previous steps: estimating your income, determining if you can lower your costs, and clarifying your current health care use can help determine which level of plan to choose. If you still find it tough to decide, a licensed benefit advisor can help you figure out which level fits the needs of you and your family.

Plan level	Average Percentage of Health Care Costs Covered (can be more or less)	Monthly Premiums (up-front costs)	Potential Out-of-pocket Costs (costs you pay when you need care)
Platinum	90%	Higher	Lower
Gold	80%		
Silver	70%		
Bronze	60%		
Catastrophic	50%	Lower	Higher

Health Plan Design

It's good to know a few things about health plan design before you go shopping. For example, health plans usually have a provider network of doctors, hospitals, specialists, and other health care professionals. It will cost you less to use the doctors and facilities that are inside your plan's network.

Different types of health plans pay different percentages of your medical expenses. A plan that pays less of your expenses will have a lower monthly premium. And a health plan that pays more of your expenses will have a higher monthly premium.

Health plans usually have a deductible. Just like your car insurance, you must spend a specific amount before your health plan begins to pay for your health expenses. But health plan deductibles can be high—up to several thousand dollars. Plans with lower premiums usually have higher deductibles.

Types of Health Plan Networks

Health Maintenance Organizations (HMOs)

This type of plan usually only pays for care that you get within its network of doctors and hospitals. HMOs require that you have a primary care physician (PCP) for treatment, coordination of care, and specialist referrals.

Exclusive Provider Organizations (EPOs)

These managed care plans require the use of in-network services only, except for emergency care. You do not need a PCP or a referral from a PCP as long as you use in-network services.

Point of Service (POS)

This type of plan allows you to get care inside and outside of the network. You pay less if you use in-network doctors, hospitals, and other health care professionals. POS plans also require you to get a referral from your PCP to see a specialist.

Preferred Provider Organizations (PPOs)

PPOs allow you to get care both inside and outside your network. But when you use out-of-network health care professionals or facilities, you pay more than when you stay in network. You do not need to get a referral from your PCP.

Enroll

Having all your information ready will help us make the best use of your time when you search for health insurance.

Collect your documents

Use this checklist to make sure you have all the documentation you'll need.

- ❍ Social Security numbers (or document numbers for immigrants) for all members of your family
- ❍ Estimated annual income (can be calculated from pay stubs or W-2 tax and income statements)
- ❍ Policy numbers for any current health coverage for anyone in your family
- ❍ Loss of coverage letter from your old provider or employer, if you have it
- ❍ A list of all prescriptions, including dosage and frequency
- ❍ Names of all your primary care physicians and other health care professionals you currently see
- ❍ Planned visits and procedures in 2020

Create your Via Benefits account online

If you haven't already done so, go to the Via Benefits website and click the **Create an account** button. As a first-time visitor, you'll need to fill in some information to get started. Then you can enter or verify additional information and add any family members who will be enrolling along with you.

Call Via Benefits

You've already scheduled a call, and now the day is here! It's all right if you're unsure about your needs or the plans that are available to you—we'll help you figure it out.

What to expect during your call

When you call us, you'll first answer a few questions through our automated system. You'll need to give your ZIP code and the last four digits of your Social Security Number.

Before you're connected with a benefit advisor licensed in your state, you may talk with other Via Benefits representatives. These representatives may collect and enter your personal information, and they can answer general questions not related to your insurance choices.

Before you get into the details of any health insurance plan, your licensed benefit advisor will work with you to see if you qualify for low- or no-cost coverage options that can make your health care more affordable.

Your Via Benefits licensed benefit advisor will ask you if there are any health plans you may be interested in. If you are unsure or want to learn more about the available plans, he or she will help you. Once you have made a decision, your licensed benefit advisor will help complete and submit your application.

You may need to have your billing, credit card, or bank information available to complete your enrollment. Some insurers may require the first month's premium payment during the application process.

After You Enroll

What happens next? Be sure to watch your mail for the items listed below.

Communications from your insurance company

You may receive mailings, phone calls, or emails directly from your new health insurance company—even before you receive formal proof of your new health coverage.

It is very important that you respond to any questions from your new health insurance company as soon as possible. They may require your response before they can give you your new policy. Via Benefits can't answer these communications for you—but if you have a question about how you should respond, please call us and we will help.

Insurance cards

You will receive insurance cards 6 to 8 weeks after the insurance company accepts your application. But rest assured that your coverage begins on the policy's effective date, not the date your insurance card(s) arrive. If you need medical care before the cards come, as long as the care is covered by your plan, the insurance company will cover it. If your cards haven't arrived and you need to see a doctor, you may have to pay out of pocket and then submit a claim later.

You may also be able to find your cards online at your health insurer's member website.

How we continue to work with you

When you get your health coverage through Via Benefits, we will continue to be your advocate for as long as you stay enrolled. Feel free to get in touch with us if you have questions about your coverage, especially with matters you'd rather not ask your insurance provider. Via Benefits can also help you enroll in Medicare coverage when you turn 65.

Sometimes your life changes and you need to change your health insurance even though it isn't the annual Open Enrollment Period. Here are a few of the events that might qualify you for a 60-day Special Enrollment Period (SEP):

- You retire before age 65
- Your marital status changes
- You lose your health coverage due to a layoff, or losing eligibility for Medicaid or CHIP, or other circumstances
- You move outside the area covered by your health insurance plan

Other events and circumstances can also make you eligible for the SEP. We are available to help you figure these things out.

Special Enrollment Period (SEP)

A time outside of the Open Enrollment Period where you are able to sign up for health coverage due to certain life events, such as early retirement. Pick a plan by the fifteenth of the month and your coverage can start the first day of the next month.

What every health insurance plan needs to include

Under the law, health plans must include items and services in at least the following categories:

- Ambulatory patient services, such as going to the doctor or visiting the hospital as an outpatient
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

While all health insurance plans must cover these services, plans may vary in the costs that you will pay for each service.

And some states require coverage for items not on this list, like hearing aids and services for autism. Check with your licensed benefit advisor if you have questions about what else may be covered.

Glossary

Benefits
The health care items or services covered under a health plan (for example, doctor visits, prescriptions, surgeries, and more).

Catastrophic coverage
Low-premium, high-deductible plans that cover certain preventative services and a limited number of primary care visits.

Coinsurance
Your share of the cost of covered medical services, usually a fixed percentage (e.g., if a hospital stay costs $1,000 and you have 15% coinsurance, you pay $150 for the service). Your insurance company will pay the rest only after you've paid your deductible.

Copay
Set amount you pay for a specific benefit (e.g., $15 for a generic drug or $20 for a doctor's office visit). You may be required to pay for specific benefits in full until your deductible is met, after which you will pay the copay amount for those benefits.

Cost sharing
How much you pay out of your own pocket for medical care covered by the plan. There are three different types of cost-sharing charges: a deductible, copayments, and coinsurance.

Coverage
The amount your insurance policy covers for health care services you use.

Deductible
You pay this amount before the plan will pay anything. For example, if you have a $1,000 deductible, your insurance company won't pay any health care costs until you've paid the full $1,000 for care you receive. The exception is certain preventative services and immunizations, which are covered at 100% even before you've met the deductible.

Exchange or marketplace
You may hear health insurance marketplaces called "exchanges." These terms mean the same thing: an online store where you can view, choose, and enroll in a health plan.

Guaranteed issue

All health plans today are guaranteed issue, which means that health insurance companies cannot deny health insurance to you or anyone in your household based on your health status, preexisting conditions, age, gender, or other factors used to predict how much you may use health services. You only need to enroll during a valid enrollment period and pay your premiums to get health coverage.

Network

Most health plans work with a specific group of doctors and health care providers. These doctors and providers have contracted to provide health care services to plan members. They have agreed to see members under certain rules, including billing at contracted rates. If you see doctors outside of your network, you will probably pay more for their services than you would for services from an in-network doctor.

Out-of-pocket costs

The amount you pay for health care services not reimbursed by insurance. This amount includes deductibles, copayments, and coinsurance for covered services, and may cover some costs for health care services your plan doesn't cover. Premiums are not counted as out-of-pocket costs, nor are costs related to out-of-network providers and non-covered services.

Out-of-pocket maximum

The most you pay during a policy period (usually a year) before your health insurance plan begins to pay 100% of the covered health benefits and qualified medical expenses (not including your premium, balance-billed charges, or services your health insurance doesn't cover). Some plans include what you pay for copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Policy

The contract between you and your insurance company. The policy spells out the details of the coverage for medical expenses that your insurance company will pay.

Tax credit

Financial assistance to help with monthly insurance premiums. You may qualify for a tax credit depending on your household income and family size.

How to Contact Us

Via Benefits can help you evaluate your options and enroll in new health coverage. Contact us today.

Contact us by phone

1-866-356-8150
(TTY: 711)

Monday through Friday
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Review your options online

marketplace.viabenefits.com/lubrizol

IMPORTANT!

When you enroll, we may collect payment information from you, depending on the type of plan you choose. If we do not collect this information from you, your insurance provider will bill you. Be sure to pay your premiums to prevent a loss of health insurance coverage.

Extend Insurance Services, LLC* is Extend Health, LLC.'s licensed insurance agency. Extend Insurance Services, LLC is a Utah resident insurance agency (Utah License No. 104741) and licensed as a nonresident insurance agency or otherwise authorized to transact business as an insurance agency in all states and the District of Columbia. Extend Insurance Services, LLC represents, and receives payment of commissions from the insurance companies for which Extend Insurance Services, LLC is an agent and sells insurance products and services, and may receive other performance-based compensation for its sale of the insurance products and services provided to you. Insurance rates for the insurance products and services offered by Extend Insurance Services, LLC are subject to change. All insurance products and services offered by Extend Insurance Services, LLC may not be available in all states. It is your responsibility to enroll for coverage during the annual Medicare Open Enrollment period.

*Extend Insurance Services, LLC is changing its d/b/a from Towers Watson's OneExchange to Via Benefits Insurance Services

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