

TERRI YUREK
INSURANCE

2016 EMPLOYEE BENEFITS
COMPLIANCE CHECKLIST FOR
GROUPS OF 50 OR FEWER FTE'S

HEALTH AND WELFARE BENEFIT PLAN

Plan Year 2016

TERRI YUREK INSURANCE SERVICES INC.
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SMALL BUSINESS COMPLIANCE CHECKLIST

Ongoing Compliance Requirements

- | | |
|---|---|
| 1. Summary Plan Description (SPD) or Wraparound Document (“Wrap”) | Follow-up Required <input type="checkbox"/> |
| <hr/> | |
| 2. Summary of Benefits & Coverage (SBC) & Uniform Glossary of Coverage (UG) | Follow-up Required <input type="checkbox"/> |
| a. Available directly from carrier – must be distributed at renewal | |
| <hr/> | |
| 3. Required Annual Notice Distribution to Employees | Follow-up Required <input type="checkbox"/> |
| a. Children’s Health Insurance Program CHIP (for employees outside of California) | |
| b. Exchange Notice | |
| c. HIPAA Privacy Notice | |
| d. COBRA Continuation Coverage General Notice | |
| e. Credible / Non-Credible Disclosure Notification | |
| f. Privacy Notice | |
| g. Women’s Health and Cancer Rights Act (WHCRA) | |
| <hr/> | |
| 4. Notice to CMS | Follow-up Required <input type="checkbox"/> |
| a. Link and instructions included in this checklist | |
| <hr/> | |
| 5. Section 125 Premium Only Plan Document (POP) | Follow-up Required <input type="checkbox"/> |
| a. For groups taking payroll deductions on a pre-tax basis | |
| b. Groups with Health Savings Accounts (HSA) must have a “Limited Purposes” POP plan | |
| c. Groups with Full Flex (FSA) plans will have this documented embedded in their FSA document | |
| <hr/> | |
| 6. Business Associate Agreement | Follow-up Required <input type="checkbox"/> |
| <hr/> | |

EMPLOYEE BENEFITS COMPLIANCE CHECKLIST

Compliance requires vigilant and constant monitoring of both federal and state laws. Did you know that failure to comply with certain compliance items below may result in penalties ranging from \$110 per day to \$1.5 million per incident? This Compliance Checklist is designed to assist you in quickly identifying what compliance provisions you've met as well as those still needing attention. Please take a moment and review items below to assess your compliance needs!

Client: _____

Date: _____

A. Ongoing Compliance Requirements

1. Summary Plan Description (SPD) and/or Wrap-around Document

In
Compliance

Not in
Compliance

- Distribute To Newly Eligible Employees: Within 90 Days
- Distributed To All Plan Participants (Including COBRA Participants)
- Electronic Delivery Permitted If Employee Has Daily Access To A Computer As Part Of Their Daily Job Duties Or Written Consent For Electronic Delivery Is Obtained From The Employee If They Do Not Have Access To A Computer As A Part Of Their Daily Job Duties

Notes / Follow-up:

2. Summary of Benefits & Coverage (SBC) & Uniform Glossary of Terms (UG)

- Updated Templates (New Coverage Examples, MV & MEC Language, etc.)
- New Electronic Delivery Guidelines, If Employees Are Enrolling Online:
 - SBCs may be delivered electronically to participants, so long as the SBC is delivered at the same time as a participant's enrollment, and enrollment was completed online
 - If the SBC is delivered electronically, the employee must also be notified of the availability to receive the SBC in paper form
 - Electronic delivery may also be provided to participants who request electronic delivery
- New Electronic Delivery Guidelines For Those COVERED Under The Plan, If Employees Are NOT Enrolling Online Notes / Follow-Up:
 - Employees may receive electronic delivery of SBCs if they have access to a computer as a part of their daily job duties

- If employee, or other individual (e.g., beneficiary), does not have access to a computer as part of their daily job duties, consent must be obtained for electronic delivery, which includes: 1) Documents to be delivered electronically; 2) Consent may be withdrawn at any time (must include procedure for withdrawal of consent, and address for delivery of SBC); 3) The right to request SBC in paper form; 4) Software and hardware requirements to view SBC (information must be updated as technology changes)

Notes / Follow-up:

**3. Required Annual Notice Distribution to Employees
(Included in Annual Notice Booklet)**

**In
Compliance**

**Not in
Compliance**

- Women’s Health & Cancer Rights Act (WHCRA) Annual Notice
<http://www.dol.gov/ebsa/publications/whcra.html>
- Medicare Part D Creditable Coverage Annual Notice
<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/CreditableCoverage/>
- Federal Children’s Health Insurance Program Reauthorization Act (CHIPRA) Notices (In Applicable States)
<https://search.usa.gov/search?affiliate=EBSA&query=CHIP&x=12&y=3>
- HIPAA Privacy Notice (Self-funded Plans, Which Include FSAs, HSAs And HRAs)
- If Distributing Electronically, The Body Of The Email Should List Which Notices Were Attached To The Email, And The Email Should Be Retained As Proof Of Delivery

Notes / Follow-up:

4. Consolidated Omnibus Budget Reconciliation Act (COBRA) Notice

In
Compliance

Not in
Compliance

- COBRA Qualifying Events (QE)
- COBRA Notices (General Notice And Election Notice)
 - [COBRA Notices](#)

Notes / Follow-up:

5. Creditable Coverage Disclosure to CMS

In
Compliance

Not in
Compliance

- Annual Disclosure: Within 60 Days Of The Beginning Of The Plan Year
- Employers Must Report Whether Their Coverage Is Creditable Or Non-Creditable To CMS
- Creditable Coverage Means That The Coverage Offered By The Plan Sponsor Reimburses Prescription Costs The Same As, Or Better Than, Medicare Part D
- Completed Online At: [CMS Reporting Link](#)
- Guidance for Completing Online Form at: [Guidance](#)

Notes / Follow-up:

6. Notice of Exchange

**In
Compliance**

**Not in
Compliance**

- Employer Contribution Statement On The Model Notice:
[Notice of Exchange](#)
- Distribute Notice To All Employees Within 14 Days Of Hire
- No Fine For Failure To Distribute The Notice

Notes / Follow-up:

SAMPLE GROUP HEALTH PLAN NOTICES
2016

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CONTENTS

Topic	Page
Legal Information Regarding Your Plans	5
The Children's Health Insurance Program (CHIP) Premium Assistance Subsidy Notice	9
Notes	

Medicare Part D Notice

3–4

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure (for use on or after 04/01/2011)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).**

LEGAL INFORMATION REGARDING YOUR PLANS

Important Notice about Your Prescription Drug Coverage and Medicare

Individual NON-CREDITABLE Coverage Disclosure (for use on or after 04/01/2011)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. For information about where you can get help to make decisions about your prescription drug coverage, contact your Human Resources Department.

There are three 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. Your employer has determined that the prescription drug coverage offered is NOT expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Non-creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your employer. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from your employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 15 to December 7.

If Your Plan is an Employer/Union Sponsored Group Plan: However, if you decide to drop your current coverage with [Insert Name of Entity], since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under employer/union sponsored group plan.

If Previous Coverage provided was Creditable Coverage: Since you are losing creditable prescription drug coverage, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

Since the coverage provided by your employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that is creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

If you decide to join a Medicare drug plan, your current coverage will be affected.

For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents.

See pages 9–11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact your Human Resources Department for further information NOTE: You'll receive this notice annually, before the next period you can join a Medicare drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: **Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.**

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits 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.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

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, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment **within 30 days** (60 days if the lost coverage was Medicaid or Healthy Families) 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.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage ⁽¹⁾
- Acquisition of a new spouse or dependent through marriage ⁽¹⁾, adoption ⁽¹⁾, placement for adoption ⁽¹⁾ or birth ⁽¹⁾
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) ⁽¹⁾
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
 - Change in legal marital status (e.g., marriage ⁽²⁾, divorce or legal separation)
 - Change in number of dependents (e.g., birth ⁽²⁾, adoption ⁽²⁾ or death)
 - Change in eligibility of a child
- Change in your / your spouse's / your **state registered / unregistered / state registered and unregistered** domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your **state registered / unregistered / state registered and unregistered** domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage ⁽³⁾
- Loss of other coverage ⁽²⁾
- **Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage**
- **You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.**

You must notify Human Resources **within 30 days** of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan will use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice.

The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

⁽¹⁾ Indicates that this event is also a qualified "Change in Status"

⁽²⁾ Indicates that this event is also a HIPAA Special Enrollment Right

⁽³⁾ Indicates that this event is also a COBRA Qualifying Event

LEGAL INFORMATION REGARDING YOUR PLANS

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on how Health Care Reform Affects Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires 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 your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider 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 your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

Important Information about COBRA Continuation Coverage and other Health Coverage Alternatives

Note: For use by single employer group health plans.

This notice has important information about your right to continue your health care coverage in your company's plan, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.healthcare.gov or call 800.318.2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

Why am I getting this notice?

You're getting this notice because your coverage under the plan will end on the last day of the month in which the following "qualifying events" occur:

- Termination of employment (18 months of COBRA)
- Reduction in hours of employment (18 months of COBRA)
- Death of employee (36 months of COBRA for the spouse and dependents)

Why am I getting this notice? (Continued)

- Divorce or legal separation (36 months of COBRA for the ex-spouse)
- Entitlement to Medicare (36 months of COBRA for the spouse and dependents)
- Loss of dependent child status (36 months of COBRA for the dependent)

Federal law requires that most group health plans (including this plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") from the list below may qualify to elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the plan because he or she is no longer a dependent under the plan

Contact your Human Resources Representative to determine eligibility for spouse and dependents.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries. Contact your Human Resources Representative for specific start and end dates for COBRA coverage.

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify Human Resources of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Other coverage options may cost less. If you choose to elect continuation coverage, additional information about payment will be provided to you after your election is received by the plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

LEGAL INFORMATION REGARDING YOUR PLANS

When can I enroll in the Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication - and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

Service Areas: Some plans limit their benefits to specific service or coverage areas - so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Important Information about Payment

First payment for continuation coverage. You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the plan. You're responsible for making sure that the amount of your first payment is correct. You may contact Human Resources to confirm the correct amount of your first payment.

Important Information about Payment (Continued)

Periodic payments for continuation coverage. After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary may be obtained by contacting Human Resources. The periodic payments can be made on a monthly basis. Under the plan, each of these periodic payments for continuation coverage is due on a specified date for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break. The plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments. Although periodic payments are due on specified dates (contact Human Resources for this information), you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the plan.

Contact your Plan Administrator for information for where your first payment and all periodic payments for continuation coverage should be sent.

Separate USERRA Rights for Military Service: The COBRA health care coverage continuation rights discussed above are separate from USERRA health care coverage continuation rights for qualifying military service.

If you leave employment to enter military service, you should contact Human Resources to determine whether you also have USERRA health care coverage continuation rights.

OMB Control Number 1210-0123 (expires 10/31/2016)

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness⁽¹⁾; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.⁽¹⁾

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months⁽²⁾, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

⁽¹⁾ The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

⁽²⁾ Special hours of service eligibility requirements apply to airline flight crew employees

LEGAL INFORMATION REGARDING YOUR PLANS

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 www.wagehour.dol.gov

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

We will not provide advance notice to you when your continuation coverage terminates.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PREMIUM ASSISTANCE SUBSIDY NOTICE

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, you can 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, you can contact your State Medicaid or CHIP office or dial (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, you can contact the Department of Labor at www.askebsa.dol.gov or call (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 January 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: www.myalhipp.com Phone: (855) 692-5447	MINNESOTA – Medicaid Website: www.dhs.state.mn.us/ Click on Healthcare, then Medical Assistance Phone: (800) 657-3629	PENNSYLVANIA – Medicaid Website: www.dpw.state.pa.us/hipp Phone: (800) 692-7462
ALASKA – Medicaid Website: health.hss.state.ak.us/dpa/programs/medicaid/ Phone (outside of Anchorage): (888) 318-8890 Phone (Anchorage): (907) 269-6529	MISSOURI – Medicaid Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	RHODE ISLAND – Medicaid Website: www.ohhs.ri.gov Phone: (401) 462-5300
COLORADO – Medicaid Website: www.colorado.gov/hcpf Phone (in-state): (800) 866-3513 Phone (out-of-state): (800) 221-3943	MONTANA – Medicaid Website: Medicaid.mt.gov/member Phone: (800) 694-3084	SOUTH CAROLINA – Medicaid Website: www.scdhhs.gov Phone: (888) 549-0820
FLORIDA – Medicaid Website: https://www.flmedicaidprecovery.com/ Phone: (877) 357-3268	NEBRASKA – Medicaid Website: www.accessnebraska.ne.gov Phone: (855) 632-7633	SOUTH DAKOTA – Medicaid Website: dss.sd.gov Phone: (888) 828-0059
GEORGIA – Medicaid Website: dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: (800) 869-1150	NEVADA – Medicaid Medicaid Website: dwss.nv.gov/ Medicaid Phone: (800) 992-0900	TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: (800) 440-0493
INDIANA – Medicaid Website: www.in.gov/fssa Phone: (800) 889-9949	NEW HAMPSHIRE – Medicaid Website: www.dhhs.nh.gov/oii/documens/hippapp.pdf Phone: (603) 271-5218	UTAH – Medicaid and CHIP Medicaid Website: health.utah.gov/upp CHIP Website: health.utah.gov/chip Phone: (866) 435-7414
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	NEW JERSEY – Medicaid and CHIP Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (609) 631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710	VERMONT – Medicaid Website: www.greenmountaincare.org/ Phone: (800) 250-8427
KANSAS – Medicaid Website: www.kdheks.gov/hcf/ Phone: (800) 792-4884	NEW YORK – Medicaid Website: www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	VIRGINIA – Medicaid and CHIP Medicaid Website: www.dmas.virginia.gov/rcp-hipp.htm Medicaid Phone: (800) 432-5924 CHIP Website: http://www.covera.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
KENTUCKY – Medicaid Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	NORTH CAROLINA – Medicaid Website: www.ncdhhs.gov/dma Phone: (919) 855-4100	WASHINGTON – Medicaid Website: www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: (800) 562-3022 ext. 15473
LOUISIANA – Medicaid Website: www.lahipp.dhh.louisiana.gov Phone: (888) 695-2447	NORTH DAKOTA – Medicaid Website: www.nd.gov/dhs/services/medicalsev/medicaid/ Phone: (800) 755-2604	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: (877) 598-5820, HMS Third Party Liability
MAINE – Medicaid Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 977-6740 TTY: (800) 977-6741	OKLAHOMA – Medicaid and CHIP Website: www.insureoklahoma.org Phone: (888) 365-3742	WISCONSIN – Medicaid Website: www.badgercareplus.org/pubs/p-10095.htm Phone: (800) 362-3002
MASSACHUSETTS – Medicaid and CHIP Website: www.mass.gov/masshealth Phone: (800) 462-1120	OREGON – Medicaid Website: www.oregonhealthykids.gov www.hijossaludablesoregon.gov Phone: (800) 699-9075	WYOMING – Medicaid Website: health.wyo.gov/healthcarefin/equalitycare Phone: (307) 777-7531

To see if any other States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

