

MI IMPORTANT NOTICES

STATE & FEDERAL DISCLOSURES



GOVERNANCE



TRANSPARENCY



REQUIREMENTS



POLICIES



LAW



RULES



STANDARDS



REGULATIONS

**MICHIGAN
PLANNERS**

EMPLOYEE BENEFITS • RETIREMENT SERVICES

About this Booklet

This booklet provides selected overview / highlights pertaining to annual compliance notices. It is not a legal document and shall not be construed, in and of itself, as a guarantee of compliance. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this booklet and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The specific Plan Administrator most often reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

Information in this Booklet should not be considered legal advice. If you have questions regarding the application of a specific notice to your benefit plan, you should seek the advice of counsel.

Throughout this booklet, terms are used to describe roles of certain individuals such as; Privacy Officer or Health Information Privacy Officer, Plan Administrator, or Human Resource Department. These roles vary by organization. Please check with your employer to determine who within your organization is responsible for these roles.

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GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on their genetic information. GINA also prohibits a group health plan from requesting or requiring an individual or a family member to undergo genetic tests. This health plan complies with GINA and does not seek research exception.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) *Privacy Overview and Notice*

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14, 2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used, and the ways in which the regulations permit it to be disclosed. To administer your benefits, information requested for enrollment must be collected and shared with your group insurance carriers. This information is about you as well as your eligible enrolled dependents and includes personal information such as name, social security number, birthdate, employee salary, address, telephone number, and possibly health history information, proof of dependent status, or other requested information specific to insurance plan provisions. In addition, business partners including Michigan Planners, Inc., also receive necessary information to assist in processing and administering your benefits in compliance with policy service and law regulations.

WHAT INFORMATION IS PROTECTED BY HIPAA PRIVACY RULES?

Information is protected when it relates to an individual's past, present, or future physical or mental condition, or to the provision or payment of health care. Under HIPAA, any electronic, paper, or oral communication transmitted by a covered entity is considered Protected Health Information, or PHI. Covered entities subject to privacy rules include; hospitals, physicians and other health care providers, health plans and claim clearinghouses.

RIGHTS OF INDIVIDUALS

The privacy rules are intended to protect the rights of individual health care consumers. Individuals have the right to:

- **Confidential communication of their PHI**
- **Inspect and copy their PHI**
- **Receive written notice of health plans' privacy practices**
- **Request restrictions on certain uses and disclosures of their PHI**
- **Request amendments to their PHI**
- **Receive an accounting of certain disclosures of their PHI**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

"We," "Us," and **"Plan"** refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to the entity stated in your Summary Plan Description or other plan documents. "You" or "yours" refers to individual participants in the Plans.

PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

We are required by the Health Insurance Portability and accountability Act (HIPAA) to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- **The Plan's uses and disclosures of Protected Health Information (PHI);**
- **Your privacy rights with respect to your PHI;**
- **The Plan's duties with respect to your PHI;**
- **Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and**
- **The person or office to contact for further information about the Plan's privacy practices.**
- **We are required by law to notify affected individuals following a breach of unsecured protected health information.**

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:

- **Maintain the privacy of your PHI;**
- **Provide you with certain rights with respect to your PHI;**
- **Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and**
- **Abide by the terms of this Notice as it may be updated from time to time.**

We protect your PHI from inappropriate use or disclosure. Our employees and those of our Business Associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services. We will not disclose your PHI to anyone for marketing purposes.

PRIMARY USES AND DISCLOSURES OF PHI

The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.

The following describe these and other uses and disclosures together with some examples:

Treatment*:

Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

Payment*:

Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services we may disclose your PHI to a provider for this purpose.

Health Care Operations Purposes*:

- 1 We may use your PHI or disclose it to others for quality assessment and improvement activities.**
- 2 We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.**
- 3 We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.**
- 4 We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, performance of health care providers, or conducting training programs.**
- 5 We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.**
- 6 We may use your PHI or disclose it to others in the process of contracting health benefits or insurance covering health care costs.**
- 7 We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.**
- 8 We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.**

Business Associates:

We contract with various individuals and entities (Business Associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree, in writing, to contract terms designed to safeguard your PHI.

Plan Sponsor:

We and our Business Associates may also disclose PHI to the Plan Sponsor without your written authorization in connection with payment, treatment, or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information. If PHI is disclosed to the Plan Sponsor for these purposes, the Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Other Covered Entities:

We (including the insured plans together) are called an "organized health care arrangement." Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

**The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purpose, as defined under the HIPAA rules.*

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

In addition to using and disclosing your PHI for treatment, payment, and health care operations purposes, we may (and are permitted) to use or disclose it in the following circumstances:

To Persons Involved in Care and for Notification Purposes:

We may disclose PHI to a family member, relative, close personal friend, or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative, or another person responsible for your care of your location, your general condition, or your death.

In Regard to Abuse, Neglect, or Domestic Violence:

In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect, or domestic violence.

In Regard To Coroners, Medical Examiners, and Funeral Directors:

We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other purpose authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.

For Public Health Activities:

We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury, or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety, or the effectiveness of products regulated by the U.S. Food and Drug Administration.

To Avert a Threat to Health or Safety:

We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

Organ and Tissue Donations:

We may, under certain circumstances, disclose PHI for purposes of organ, eye, or other medical transplants or tissue donation purposes.

To Comply with Workers' Compensation Laws:

We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.

For Law Enforcement and National Security Purposes:

In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes; for example, if it is required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.

In Connection with Legal Proceedings:

In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information but only after certain conditions required by HIPAA are met.

For Health Oversight Activities:

We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws, or government benefit. Health oversight activities include audits, inspections, investigations, or legal proceedings.

Military Personnel:

If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.

Inmates:

If you are incarcerated, we may disclose your PHI to appropriate authorities who tell us they need it for your health care, your safety, the health or safety of other persons, or general administrative purposes.

Research:

Under certain circumstances, we may disclose PHI for research purposes.

Health Information:

We may contact you with information about treatment alternatives and other health-related benefits and services.

As Required by Law:

We may disclose your PHI when required to do so by federal, state, or local law.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures we are required by law to make:

Disclosures to the Secretary of the U.S. Department of Health & Human Services:

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.

Disclosure to You:

We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

Other Uses And Disclosures Of Your PHI With Authorization:

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call the Human Resource Department. You may revoke an authorization by contacting the Health Information Privacy Officer.

YOUR RIGHTS

Right to Request Restrictions on Use and Disclosure:

You may ask us to restrict use and disclosures of your PHI for treatment, payment, or health care operations or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions except in those situations where the requested restrictions relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid out of pocket in full. You may exercise this right by contacting the Health Information Privacy Officer who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy, and Amend Your PHI:

As long as We maintain records containing your PHI, you have a right to inspect and copy such information. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. If you believe your PHI held and created by Us is incorrect or incomplete, you may request that We amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer.

Right to a List of Disclosures:

You have a right to an accounting of certain disclosures of your PHI by Us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment, or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer.

Right to Request Confidential Communications:

We will accommodate a reasonable request by you to receive communications from Us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer.

Right to be Notified of a Breach:

You have the right to be notified in the event that We (or a Business Associate) discovered a breach of unsecured PHI.

Right to Receive Paper Copy:

You have the right to receive a paper copy of this Notice from the Plan upon request even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice you will receive a new notice. Active employees will receive the Notice by distribution in the workplace; inactive employees will receive the Notice by mail.

Complaints:

If you believe that your privacy rights have been violated, you may complain to Us in writing or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC 20201. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer:

The Human Resource Department can provide contact information for the Health Information Privacy Officer.



MEDICARE PART D

CREDITABLE OR NON-CREDITABLE COVERAGE NOTICE OVERVIEW

THIS IS AN OVERVIEW OF MEDICARE PART D NOTICES. NOTICES SPECIFIC TO THE DRUG PLANS OFFERED BY YOUR EMPLOYER WHICH ARE CREDITABLE OR NON-CREDITABLE WILL BE DISTRIBUTED ANNUALLY PRIOR TO OCTOBER 14TH BY YOUR EMPLOYER.

Your Medicare Part D Notice has information about the current prescription drug coverage available under the Plan provided by your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is provided at the end of your applicable Medicare Part D Notice.

Medicare beneficiaries who are not covered by creditable prescription drug coverage and who choose not to enroll in Medicare Part D before the end of their initial enrollment period will likely pay higher premiums if they later enroll in Part D prescription drug coverage.

NOTICE OF YOUR MEDICARE PART D CREDITABLE COVERAGE STATUS

Under the Medicare Part D program, group health plans - like this Plan - are required to provide or arrange for providing a notice of creditable prescription drug coverage at least annually to those Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the Plan. You will also be provided with your creditable coverage status at the following times:

- **Prior to your initial enrollment period;**
- **Prior to your effective date of coverage if you are a Medicare Part D eligible individual who enrolls in your Employer's Group Health Plan prescription drug coverage;**
- **Whenever your prescription drug coverage ends or changes so that it is no longer creditable; and**
- **Upon your request.**



MEDICARE SECONDARY PAYER

MANDATORY REPORTING

As a subscriber (or spouse or family member of a subscriber) to a Group Health Plan (GHP) arrangement, it is likely that your employer or insurer will ask for proof of your Medicare program coverage by asking for your Medicare HICN (or your SSN) to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment, or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning whether or not they (or the injured party if the settlement, judgment or award is based on an injury to someone else) are Medicare beneficiaries and, if so, to provide their HICNs or SSNs. Employers, insurers, TPAs, etc., will be asked for EINs. For further information on the mandatory reporting requirements under this law, please visit <http://www.cms.gov> on the CMS website.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

NEWBORNS ACT DISCLOSURE

This notice is being provided to inform you of the Federal requirements relating to hospital lengths of stay in connection with childbirth.

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



PREMIUM ASSISTANCE UNDER MEDICAID

AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102</p>
<p align="center">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>	<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofl/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofl/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p>SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>
<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p>NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>	<p>VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924</p>
<p>OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p>WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
<p>PENNSYLVANIA – Medicaid</p> <p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p>WEST VIRGINIA – Medicaid and CHIP</p> <p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>	<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p>SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

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



SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

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

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact your Human Resource Department.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

In 1998, Congress enacted the Women's Health & Cancer Rights Act (WHCRA). This notice explains some important provisions of the Act.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- **All stages of reconstruction of the breast on which the mastectomy was performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **Prostheses; and**
- **Treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your health insurance company or your Plan Administrator (Human Resource Department).



SUMMARY OF BENEFITS & COVERAGE (SBC)

A summary of benefits and coverage (SBC) is a summary of plan benefits coverage and cost-sharing arrangements required under the Affordable Care Act. Group health plans and health insurance issuers provide SBCs to participants. Generally an SBC is provided for each health benefit option available to you under the plan and is provided to you annually at open enrollment and upon renewal or reissuance of coverage. If your plan is self-funded, the Plan Administrator will provide an SBC. If the plan is insured, the Plan Administrator and issuer will provide the SBC.

Other times an SBC must be provided:

- **Upon application (i.e., when you are initially eligible for coverage);**
- **By the first day of coverage (if there have been any changes);**
- **When an event triggers HIPAA special enrollment rights; and**
- **Within 7 business days upon request.**

NOTE: You will receive SBC(s) relevant to your health plans separately.

GLOSSARY OF HEALTH COVERAGE & MEDICAL TERMS

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

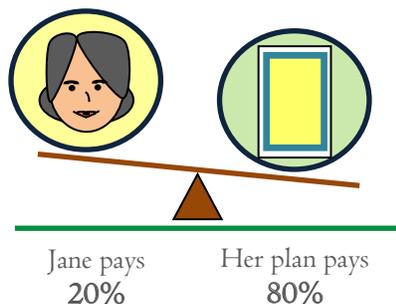
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Cost Sharing

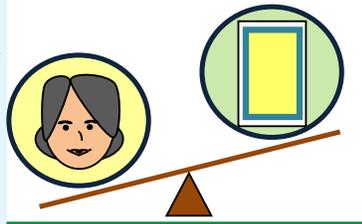
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays	Her plan pays
100%	0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

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

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

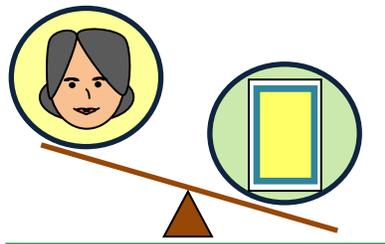
Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

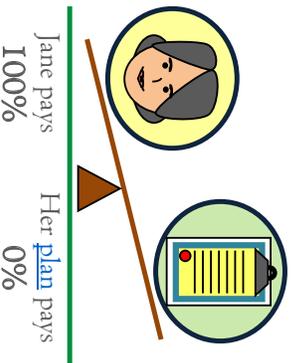
Jane's Plan Deductible: \$1,500

Coinurance: 20%

Out-of-Pocket Limit: \$5,000

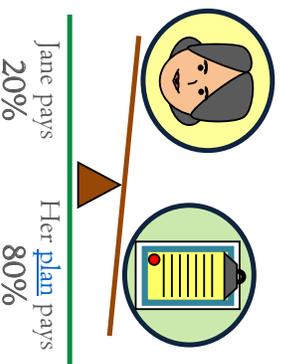
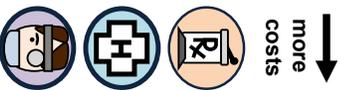
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



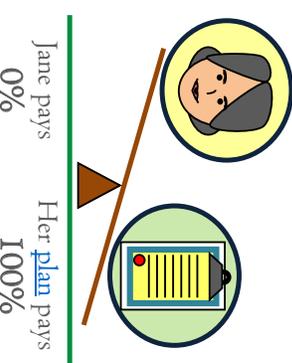
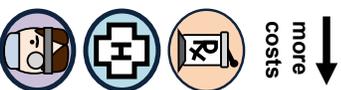
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0



Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: \$125
Jane pays: 20% of \$125 = \$25
Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$125
Jane pays: \$0
Her plan pays: \$125

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



SOCIAL SECURITY NUMBER PRIVACY ACT

The State of Michigan Public Act 454 took effect March 1, 2005. The Act contains a number of protective measures applicable to all business entities, including schools and libraries, to ensure the security of social security numbers, including those of its employees and if applicable, its patrons or students. Generally, the Social Security Number Privacy Act places restrictions on the use, display, and disclosure of social security numbers that are obtained in the ordinary course of business.

Michigan Planners employees and the carriers we represent are expected to follow the requirements of the Social Security Number Policy adopted Michigan Planners or the Carrier. Including, protecting the confidentiality of the Social Security Numbers, prohibition of disclosure of Social Security Numbers, limits to access of information or documents that contain Social Security Numbers, proper disposal of Social Security Numbers. Penalties are in place for violation of the policy.



MICHIGAN'S ABORTION OPT-OUT ACT

This notice is applicable to participants who are enrolled in a fully-insured health plan with a voluntary abortion rider. Refer to your health insurance company Benefits-at-a-Glance or Benefit Summary or, contact your health insurance company to see if this rider is included in your group health plan coverage.

The State of Michigan Public Act 182 of 2013, titled Abortion Insurance Opt-Out Act, requires the purchase of coverage for elective abortion in a health care plan to be by an optional rider only which carries an additional premium for inclusion of this optional coverage; requires notice to employees for whom elective (as defined by MCL 550.551) abortion coverage is purchased by their employer; and provides penalties for violations of this Act. The following notice is intended to fully comply with the employer mandate in MCL 550.544, and hereby notifies each employee: Elective abortions (as defined by MCL 550.551) will be included as a rider to your group health plan coverage and this group health coverage may be used by a covered dependent without notice to the employee.

COBRA CONTINUATION COVERAGE

You may have other options available to you when you lose group health coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

IMPORTANT NOTE: THE FOLLOWING IS INTENDED TO PROVIDE A SIMPLIFIED OVERVIEW OF THE COBRA LAW AND IS TO BE USED FOR INFORMATIONAL PURPOSES ONLY.

MOST EMPLOYERS USE A THIRD-PARTY ADMINISTRATOR (TPA) FOR THEIR COBRA NOTIFICATIONS. IF YOUR COMPANY USES A TPA, YOU WILL RECEIVE THE REQUIRED GENERAL NOTICE WHICH EXPLAINS IN SPECIFIC DETAIL WHAT COBRA CONTINUATION COVERAGE IS AND WHEN IT IS AVAILABLE TO YOU AND YOUR DEPENDENTS. IF YOUR EMPLOYER DOES NOT USE A TPA, NOTICES WILL COME DIRECTLY FROM THE EMPLOYER.

WHAT IS COBRA CONTINUATION HEALTH COVERAGE?*

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

WHAT DOES COBRA DO?*

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves.

WHICH EMPLOYERS ARE REQUIRED TO OFFER COBRA COVERAGE?*

Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

UNDER COBRA, WHAT BENEFITS MUST BE COVERED?*

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

WHO CAN ANSWER OTHER COBRA QUESTIONS?*

COBRA administration is shared by three federal agencies. The U.S. Department of Labor handles questions about notification rights under COBRA for private-sector employees. The Department of Health and Human Services handles questions relating to state and local government workers. The Internal Revenue Service, Department of the Treasury, has other COBRA jurisdiction.

**The above information was taken from "Frequently Asked Questions about COBRA Continuation Health Coverage" on the Department of Labor website (dol.gov).*



FAMILY & MEDICAL LEAVE ACT OF 1993

AND NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2010

THIS IS A GENERAL OVERVIEW OF FMLA. DETAILS SPECIFIC TO YOUR ORGANIZATION WILL BE PROVIDED BY YOUR EMPLOYER.

The FMLA applies to all public agencies, including state, local and federal employers, local education agencies (schools), and private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.

On October 28, 2009, the President signed the National Defense Authorization Act for Fiscal Year 2010 (2010 NDAA), Public Law 111-84. Section 565 of the 2010 NDAA amends the military family leave entitlements of the Family and Medical Leave Act (FMLA). The FMLA entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any “qualifying exigency” arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a “single 12-month period” to care for a covered service member with a serious injury or illness.

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- **The birth of a child or placement of a child for adoption or foster care;**
- **To bond with a child (leave must be taken within one year of the child's birth or placement);**
- **To care for the employee's spouse, child, or parent who has a qualifying serious health condition**
- **For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;**
- **For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.**

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- **Have worked for the employer for at least 12 months;**
- **Have at least 1,250 hours of service in the 12 months before taking leave;* and**
- **Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.**

**Special "hours of service" requirements apply to airline flight crew employees.*

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

THIS DISCLOSURE WILL APPLY ONLY FOR GROUP HEALTH PLANS OFFERING A WELLNESS PROGRAM THAT REQUIRES AN INDIVIDUAL TO SATISFY A STANDARD RELATED TO A HEALTH FACTOR.

WELLNESS PROGRAM DISCLOSURE

New rules published on May 17, 2016, under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential.

WELLNESS NOTICES:

HIPAA imposes a notice requirement on health contingent wellness programs that are offered by group health plans. A health contingent wellness program requires individuals to satisfy standards related to health factors in order to obtain rewards. If you are eligible to participate in a health contingent wellness program, you will receive a **General Disclosure Notice*** describing the incentives available to employees based on attainment of certain health outcomes (for example, receiving certain results on biometric screenings) or participation in an activity (for example, participating in a walking or exercise program). A reasonable alternative standard (or waiver) must be offered to an individual; 1) for an activity-only wellness program if it is unreasonably difficult due to a medical condition or inadvisable to attempt to satisfy the standard; or 2) if you fail to meet the designated initial standard of an outcome based program. Under the Americans with Disabilities Act (ADA), employers that offer wellness programs that collect employee health information are required to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential (**EEOC ADA Wellness Program Disclosure***). Also, if the program requests family or genetic information, written authorization is required by employees and spouses and it must indicate the genetic information obtained, how it will be used and any restrictions on its disclosure. This information must be communicated in a **GINA Wellness Disclosure***. Recommendations of an individual's personal physician will be accommodated.

**If any of these Wellness Notices are applicable to your Plan, your Plan Administrator will provide the required Notice(s) to you. Contact your Plan Administrator for more details.*



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