**Sample Open Enrollment Notices Packet**

**Delete the notices that do not apply to your situation. You should also review each notice you need to give, modify it as needed to describe your plan, and fill in any blanks or highlighted areas.**

Important NoticeS from COMPANY NAME regarding the PLAN NAME

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

**If you have any questions regarding any of these notices, please contact:**

General Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If applicable:*

Privacy Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Distribution Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If applicable:*

***These notices are available online at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or via paper, free of charge, upon request to the Plan Administrator.***

*Please note this is not a legal document and should not be construed as legal advice.*

**Provide this notice by October 14 to all participants and dependents who are or may become eligible for Medicare Part D in the next 12 months if the prescription drug coverage provided by the plan is “creditable.” (Your carrier or Rx vendor can tell you if the coverage is creditable.)**

**Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:**

**1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

**2. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**



**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current [Insert Name of Entity] coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity’s plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity’s plan will end for the individual and all covered dependents, etc.). See pages 7- 9 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 [Insert Name of Entity] coverage, be aware that you and your dependents will [or will not] [Medigap issuers must insert *“will not “*] be able to get this coverage back.

**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 [Insert Name of Entity] and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage**

Contact the person listed below for further information [or call [Insert Alternative Contact] at [(XXX) XXX-XXXX]. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [Insert Name of Entity] 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](http://www.medicare.gov)
* Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
* Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**[Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]**

Medicare Eligible Individual’s Name: [Insert Full Name of Medicare Eligible Individual]

Individual’s DOB or unique Member ID: [Insert Individual’s Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date: [Insert MM/DD/YY]

Name of Entity/Sender: [Insert Name of Entity]

Contact--Position/Office: [Insert Position/Office]

Address: [Insert Street Address, City, State & Zip Code of Entity]

Phone Number: [Insert Entity Phone Number]

**Provide this notice by October 14 to all participants and dependents who are or may become eligible for Medicare Part D in the next 12 months if the prescription drug coverage provided by the plan is *not* “creditable.” (Your carrier or Rx vendor can tell you if the coverage is creditable.)**

**Important Notice From [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**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. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is 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 the [Insert Name of Plan]. This also is 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 [Insert Name of Plan]. 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 15th to December 7th.

**[INSERT IF 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 [Insert Name of Plan.**]**

**[INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE:** Since you are losing creditable prescription drug coverage under the [Insert Name of Plan], 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 under [Insert Name of Plan], 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’s 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 Drug Plan?**

If you decide to join a Medicare drug plan, your current [Insert Name of Entity] coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity’s plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity’s plan will end for the individual and all covered dependents, etc.). [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 [Insert Name of Entity] coverage, be aware that you and your dependents will [or will not] [Medigap issuers must insert *“will not”*] be able to get this coverage back.

**For More Information About This Notice Or Your Current Prescription Drug Coverage**

Contact the person listed below for further information. [or call [Insert Alternative Contact] at [(XXX) XXX-XXXX]. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through [Insert Name of Entity] 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](http://www.medicare.gov)
* Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
* Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**[Optional Insert – If a beneficiary has had creditable coverage under the entities plan for any period of time since May 15, 2006, entities can insert the following information box if they choose to provide a personalized disclosure notice.]**

Medicare Eligible Individual’s Name: [Insert Full Name of Medicare Eligible Individual] Individual’s DOB or unique Member ID: [Insert Individual’s Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [Insert MM/DD/YY] To: [Insert MM/DD/YY]

From: [Insert MM/DD/YY] To: [Insert MM/DD/YY]

Date: [MM/DD/YY]

Name of Entity/Sender: [Insert Name of Entity]

Contact--Position/Office: [Insert Position/Office]

Address: [Insert Street Address, City, State & Zip Code of Entity]

Phone Number: [Insert Entity Phone Number]

**Provide this notice at least once a year to all participants:**

**Women’s Health and Cancer Rights Act Notice**

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at [insert phone number] for more information.

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. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits.] If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

**Provide this notice at least once a year to all participants.**

**Newborns’ and Mothers’ Health Protection Act**

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

**Provide this notice before the start of the plan year if you have any employees in a state listed in the notice. (These states provide premium assistance for CHIP and/or Medicaid coverage.) Caution: This notice is updated regularly. Check at** [**www.dol.gov/ebsa/chipmodelnotice.doc**](http://www.dol.gov/ebsa/chipmodelnotice.doc) **for the most current version if you do not promptly distribute this 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, 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, you can ask the 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 are not 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 electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or by calling toll-free 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, 2019. Contact your State for more information on eligibility.**

|  |  |
| --- | --- |
| **ALABAMA – Medicaid** | **FLORIDA – Medicaid** |
| Website: <http://myalhipp.com/>Phone: 1-855-692-5447 | Website: <http://flmedicaidtplrecovery.com/hipp/>Phone: 1-877-357-3268 |
| **ALASKA – Medicaid** | **GEORGIA – Medicaid**  |
| The AK Health Insurance Premium Payment ProgramWebsite: <http://myakhipp.com/> Phone: 1-866-251-4861Email: CustomerService@MyAKHIPP.comMedicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx> | Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp> Phone: 678-564-1162 ext 2131 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid**  |
| Website: <http://myarhipp.com/>Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64Website: <http://www.in.gov/fssa/hip/>Phone: 1-877-438-4479All other MedicaidWebsite: [http://www.indianamedicaid.com](http://www.indianamedicaid.com/)Phone 1-800-403-0864 |
| **COLORADO – Health First Colorado(Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)** | **IOWA – Medicaid** |
| Health First Colorado Website: <https://www.healthfirstcolorado.com/> Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus> CHP+ Customer Service: 1-800-359-1991/State Relay 711 | Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563  |
| **KANSAS – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: <http://www.kdheks.gov/hcf/>Phone: 1-785-296-3512 | Website: <https://www.dhhs.nh.gov/oii/hipp.htm> Phone: 603-271-5218Toll free number for the HIPP program: 1-800-852- 3345, ext. 5218  |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://chfs.ky.gov Phone: 1-800-635-2570 | Medicaid Website:<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>Medicaid Phone: 609-631-2392CHIP Website: <http://www.njfamilycare.org/index.html>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>Phone: 1-888-695-2447 | Website: <https://www.health.ny.gov/health_care/medicaid/>Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>Phone: 1-800-442-6003TTY: Maine relay 711 | Website: <https://dma.ncdhhs.gov/> Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>Phone: 1-800-862-4840 | Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp>Phone: 1-800-657-3739 | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org/)Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>Phone: 573-751-2005 | Website: <http://healthcare.oregon.gov/Pages/index.aspx><http://www.oregonhealthcare.gov/index-es.html>Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>Phone: 1-800-694-3084 | Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>Phone: 1-800-692-7462 |

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| --- | --- |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website: <http://www.ACCESSNebraska.ne.gov>Phone: (855) 632-7633Lincoln: (402) 473-7000Omaha: (402) 595-1178  | Website: <http://www.eohhs.ri.gov/>Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** |
| Medicaid Website: https://dhcfp.nv.govMedicaid Phone: 1-800-992-0900 | Website: <https://www.scdhhs.gov>Phone: 1-888-549-0820 |
| **SOUTH DAKOTA - Medicaid** | **WASHINGTON – Medicaid** |
| Website: [http://dss.sd.gov](http://dss.sd.gov/)Phone: 1-888-828-0059 | Website: <https://www.hca.wa.gov/> Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: <http://gethipptexas.com/>Phone: 1-800-440-0493 | Website: <http://mywvhipp.com/>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Medicaid Website: <https://medicaid.utah.gov/>CHIP Website: <http://health.utah.gov/chip>Phone: 1-877-543-7669 | Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: <http://www.greenmountaincare.org/>Phone: 1-800-250-8427 | Website: <https://wyequalitycare.acs-inc.com/>Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** |  |
| Medicaid Website: <http://www.coverva.org/programs_premium_assistance.cfm>Medicaid Phone: 1-800-432-5924CHIP Website: <http://www.coverva.org/programs_premium_assistance.cfm>CHIP Phone: 1-855-242-8282 |

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa) [www.cms.hhs.gov](http://www.cms.hhs.gov)

1-866-444-EBSA (3272) 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 ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

[Sample Open Enrollment Notice](https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf) OMB Control Number 1210-0137 (expires 12/31/2019)

**Provide this notice only if you have a wellness program that considers health status.**

**Wellness Program – Notice of Reasonable Alternatives**

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

**Provide this notice only if you have a wellness program that includes a health risk assessment, biomedical screening, or medical exam (including incentives for having a yearly physical, etc.)**

**Notice Regarding Wellness Program**

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information].

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You also are encouraged to share your results or concerns with your own doctor.

**Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information].

Language should be added indicating the employer complies with HIPAA’s privacy and security measures as applicable.

**Provide this notice only if the plan is grandfathered.**

**Grandfathered Plan Notice**

This [group health plan or health insurance issuer] believes this [plan or coverage] is a ‘‘grandfathered health plan’’ under the Patient Protection and Affordable Care Act (the Affordable Care Act). 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 or policy] 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 at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or [www.dol.gov/ebsa/ healthreform](http://www.dol.gov/ebsa/healthreform)*.* This Website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](https://www.hhs.gov/).]

**Provide this notice if the plan requires designation of a primary care provider; tailor as needed.**

**Patient Protection Notice**

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

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

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, add:**

You do not need prior authorization from [name of group health plan or issuer] 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 the [plan administrator or issuer] at [insert contact information].

**Provide this notice every three years or less.**

**HIPAA Notice of Privacy Practices**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

**Covered entities such as health plans may use the following HHS’ Module Notice of Privacy Practices - Health Plan by entering their specific information. Covered entities should review HHS’** [**Questions and**](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/q_and_i-use_of_model_notices.pdf) **Instructions before personalizing the notice.**

**Your Information. Your Rights. Our Responsibilities.**

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.**

**Your Rights**

You have the right to:

* Get a copy of your health and claims records
* Correct your health and claims records
* Request confidential communication
* Ask us to limit the information we share
* Get a list of those with whom we’ve shared your information
* Get a copy of this privacy notice
* Choose someone to act for you
* File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

* Answer coverage questions from your family and friends
* Provide disaster relief
* Market our services and sell your information

**Our Uses and Disclosures**

We may use and share your information as we:

* Help manage the health care treatment you receive
* Run our organization
* Pay for your health services
* Administer your health plan
* Help with public health and safety issues
* Do research
* Comply with the law
* Respond to organ and tissue donation requests and work with a medical examiner or funeral director
* Address workers’ compensation, law enforcement, and other government requests
* Respond to lawsuits and legal actions

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get a copy of health and claims records**

* You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
* We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

* You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
* We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
* We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations.
* We are not required to agree to your request, and we may say “no” if it would affect your care.

**Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

* You can complain if you feel we have violated your rights by contacting us using the information on page 1.
* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
* We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in payment for your care
* Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we *never* share your information unless you give us written permission:

* Marketing purposes
* Sale of your information

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

* We can use and disclose your information to run our organization and contact you when necessary.
* We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

* We can share health information about you with organ procurement organizations.
* We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)**.**

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

**Other Instructions for Notice**

* Insert Effective Date of this Notice
* Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
* Insert any special notes that apply to your entity’s practices such as “we do not create or manage a hospital directory” or “we do not create or maintain psychotherapy notes at this practice.”
* The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, “We will never share any substance abuse treatment records without your written permission.” Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
* If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
* If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, “This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area.”

**Provide this notice only if the plan is a self-funded nonfederal governmental group health plan that has opted out of some or all of HIPAA; tailor as needed to describe what the plan has opted out of.**

**Notice to Enrollees Regarding Opt-Out**

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. [Name of plan sponsor] has elected to exempt [name of plan] from [all or specify which ones] of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the [plan year] [period of plan coverage] beginning [specify date] and ending [specify date]. The election may be renewed for subsequent plan years.

Per the Genetic Information Nondiscrimination Act (GINA), the opt-out does not prevent HIPAA’s portability and nondiscrimination requirements from applying to genetic information. Further, the opt-out does not apply to GINA’s restrictions on requesting, requiring, collecting and using genetic information.

**ADDITIONAL NOTICES FOR NEW ENROLLEES**

**Give this notice to all new enrollees.**

**Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within [insert “30 days” or any longer period that applies under the plan] 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 [insert “30 days” or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children’s Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within [insert “60 days” or any longer period that applies under the plan] after your or your dependents’ Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within [insert “60 days” or any longer period that applies under the plan] after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

**Give this notice to all new enrollees – including new spouses – if you employ 20 or more people. (Please be aware that many states have “mini-COBRA” laws that may require an employer or plan sponsor to provide additional, different notice of “mini-COBRA” rights.)**

**\*\* Continuation Coverage Rights Under COBRA \*\***

**Introduction**

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

**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.

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren’t required to pay] for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your hours of employment are reduced, or
* Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your spouse dies;
* Your spouse’s hours of employment are reduced;
* Your spouse’s employment ends for any reason other than his or her gross misconduct;
* Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
* You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

* The parent-employee dies;
* The parent-employee’s hours of employment are reduced;
* The parent-employee’s employment ends for any reason other than his or her gross misconduct;
* The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
* The parents become divorced or legally separated; or
* The child stops being eligible for coverage under the Plan as a “dependent child.”

[*If the Plan provides retiree health coverage, add the following paragraph:*]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

* The end of employment or reduction of hours of employment;
* Death of the employee;
* [*add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
* The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*].[*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]**

**How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other 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 can learn more about many of these options at www.healthcare.gov.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](https://www.dol.gov/agencies/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep your Plan informed of address changes**

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members.You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan contact information**

[*Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.*]

***Provide this notice to all new employees (even if they are part-time/temporary/not eligible for the plan) within 14 days after their hire date if you offer coverage to any employee. Note that completing questions 13 – 16 is optional. At this time, providing information on minimum value and affordability is required.***

For the Department of Labor’s Employer Exchange/Marketplace Notices and Instructions, please click the link below:

[http://www.datair.com/PDF/DOL Employer Exchange Notices.pdf](http://www.datair.com/PDF/DOL%20Employer%20Exchange%20Notices.pdf)



**New Health Insurance Marketplace Coverage**

Form Approved

 OMB No. 1210-0149

(expires 5-31-2020)

**Options and Your Health Coverage**

**PART A: General Information**

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

**What is the Health Insurance Marketplace?**

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

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

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

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

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

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

**How Can I Get More Information?**

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [**HealthCare.gov**](http://www.healthcare.gov/) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

**PART B: Information About Health Coverage Offered by Your Employer**

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

|  |  |
| --- | --- |
| 3. Employer name | 4. Employer Identification Number (EIN) |
| 5. Employer address | 6. Employer phone number |
| 7. City | 8. State | 9. ZIP Code |
| 10. Who can we contact about employee health coverage at this job? |
| 11. Phone number (if different from above) | 12. Email address |

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

* As your employer, we offer a health plan to:
* All employees. Eligible employees are:
* Some employees. Eligible employees are:
* With respect to dependents:
* We do offer coverage. Eligible dependents are:
* We do not offer coverage.
* If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [**HealthCare.gov**](http://www.healthcare.gov/) will guide you through the process. Here's the employer information you'll enter when you visit [**HealthCare.gov**](http://www.healthcare.gov/) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. **Completing this section is optional for employers,** but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

**□** **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

* **No** (STOP and return this form to employee)

|  |
| --- |
| 14. Does the employer offer a health plan that meets the minimum value standard\*?□ Yes (Go to question 15) □ No (STOP and return form to employee) |
| 15. For the lowest-cost plan that meets the minimum value standard\* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.a. How much would the employee have to pay in premiums for this plan? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □ Yearly |

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? \_\_\_\_\_\_\_\_\_\_

□ Employer won't offer health coverage

□ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $\_\_\_\_\_\_\_\_\_\_\_

b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)