

Important Notices

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision (if applicable) coverage because you terminate employment (for reason other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions that protect the privacy of health plan participants. These provisions, which went into effect April of 2003, govern how covered entities such as health insurance companies and the plan sponsor must handle protected health information. The company distributes HIPAA Privacy Notices in accordance with Federal Regulations. If you need to obtain a copy of the HIPAA Privacy Notice please contact Human Resources.

GINA

The Genetic Information Nondiscrimination Act (GINA) states that Under a 2009 federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

MENTAL HEALTH PARITY

In 2009, the Wellstone Act added to the requirements of the 1996 Mental Health Parity Act (MHPA). The new act has extended parity requirements to substance use disorder benefits in addition to mental health benefits. It prohibits applying financial requirements (e.g. copayments and deductibles) or treatment limitations (e.g. annual limits on outpatient visits or hospital days) to mental health or substance use disorders unless those requirements and limitations are no more restrictive than those that apply to most medical and surgical benefits. The act also maintained the MHPA's ban on lower annual or lifetime dollar limits for mental health benefits.

MICHELLE'S LAW

Michelle's Law is a federal law that allows continued coverage for seriously ill college students. A college student will be able to maintain health plan eligibility for up to one year after full-time student status is lost due to a medically necessary leave of absence from school. "Michelle's Law" was named after New Hampshire college student Michelle Morse, who, despite being diagnosed with cancer, attended school full-time to stay enrolled in her parent's health insurance.

NEWBORN'S & MOTHER'S 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH & CANCER RIGHTS

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the Human Resources Department.

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 August 10, 2017. 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 Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx		Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	
ARKANSAS – Medicaid		INDIANA – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)		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: 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 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 711		Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	

<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">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 align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p align="center">MINNESOTA – Medicaid</p> <p>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</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</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">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 align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>

SOUTH DAKOTA - Medicaid		WASHINGTON – Medicaid	
Website: http://dss.sd.gov Phone: 1-888-828-0059		Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 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: 1-800-432-5924 CHIP 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 August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

and Human Services Employee Benefits Security Administration
Medicare & Medicaid Services www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health

Centers for
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 ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Arizona state law has a surprise billing process available to PPO members of insured plans and self-funded plans sponsored by government organization employers. Under the Arizona process, a member can dispute certain surprise bills from out-of-network professional providers if the member is balance billed for an amount over \$1,000 and the service was rendered in a network facility. There are other requirements for the bill to qualify for review under this process, and the Arizona Department of Insurance and Financial Institutions (DIFI) determines if the bill qualifies. The member must initiate the process through the DIFI and participate in an initial settlement conference. See the DIFI's website at **Surprise Out-of-Network Bill Dispute Resolution | DIFI (az.gov)**.

You're **never** required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.