Mineral MITRATECH

Convergence Insurance & Advisory Services



Benefit Notices for Open Enrollment

Use these templates to prepare required benefit notices and disclosures for employees during open enrollment.

Version 1.6 | August 2026

Table of Contents

How to Use this Packet	3
Notices Information Grid	4
Notices Chart (with links)	7
Notices	9

How to Use this Packet

Employers sponsoring group health plans must provide certain notices and disclosures to individuals who are eligible for benefits.

These materials are generally referred to as "open enrollment benefit notices." This printable guide contains the notices and templates needed to prepare required benefit notices.

Employers and their advisors can use the grid starting on the next page to prefill all notices contained in this package, which auto-populates to each notice or form. Review each notice carefully after populating to ensure accuracy and applicability. Make sure to save a copy of the PDF after filling out the grid or your answers will be lost. Print individual forms or the whole packet.

Links in the Notices Chart will take you to the individual notices posted on the applicable regulatory site, but we have included each notice in this packet. Some are reproductions of agency notices and some are created and provided by Mineral, but are legally compliant.

To get started, review the chart along with guidance about which notices to include for your plan. Answer the questions in the grid starting on the next page.

After filling out all the information in the grid, you can print each notice, and discard those that don't apply. You can identify applicable notices by looking for a check mark in the "Include" box, located either at the top or bottom of the notice. Also, if there is no "Include" box, you can assume the notice applies to your business.

If you'd like to print only the notices that apply to you, simply note the corresponding page numbers and use the "print" feature to select those specific pages. Note that there is currently no feature to automatically filter and print only applicable notices, so the steps above will help guide you through this process.

When selecting No to a question, you do not need to answer the sub-questions below it and can move on to the next questions.

Pages for the notices that correspond to the grid questions are noted beside the applicable question. Note that while we have chosen not to number the pages where notices reside, any page numbers shown here or in the grid will correspond with the page numbers of the PDF.

After the grid is completed, review it to ensure the notices will populate accurately. If a notice populates incorrectly, review the grid and make adjustments as needed.

If you do not offer a group medical plan, but do offer a group health plan (e.g., dental, vision) and are subject to federal COBRA laws, the COBRA notice beginning on page 17 may still apply. Complete the COBRA section in the grid that begins on the bottom of page 5. State continuation notices are not included in this packet.

Insured Health Plans: Plans provided through group insurance policies are subject to state insurance laws that may apply in addition to, or in place of, one or more of the federal notices in this package. In that case, the insurance carrier provides the applicable notices, which may be distributed with enrollment materials or included in the carrier's evidence of coverage (EOC) booklet. Employers are advised to coordinate with the carrier to ensure that all requirements are met under both federal and state law.

HIPAA Privacy Notices: Employers sponsoring one or more group health plans that are subject to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules may be responsible for their plan's compliance with the rules, including the requirement to prepare and distribute a Notice of Privacy Practices (Privacy Notice) to plan participants. The requirements vary widely, depending on whether the plan is insured or self-funded, the extent to which the employer has access to personal health information (PHI), the use of electronic media, and other factors. Due to these variables, information about Privacy Notices is not provided here, and employers are advised to review their plan or plans with legal counsel offering expertise in HIPAA. See also our Employer Guide to HIPAA Privacy and Security Rules.

Multiemployer Plans, Multiple Employer Welfare Arrangements, and Association Health Plans: This material is designed for use by *single-employer plans only*. Do not use for multiemployer plans (e.g., union trusts), multiple employer welfare arrangements (MEWAs), or association health plans.

Note that the grid is mapped to and will complete the various notices in this packet, but does not ensure accuracy. Employers and their advisors must review all material and are responsible for the accuracy of the information provided here.

Notices Information Grid

Date of notice creation	
Employer name	
Employer Identification Number (EIN)	
Employer contact name	
Employer phone number	
Employer email address	
Employer street address	
Employer city	
Employer state (abbreviation)	
Employer ZIP	
Number of employees	☐ 1–19 ☐ 20–49 ☐ 50+
Do you sponsor a group health plan? **If yes**, complete the plan information below:	☐ Yes ☐ No
Is the plan governed by ERISA?	☐ Yes ☐ No
Plan name	
Plan admin contact name	
Plan admin contact phone number	
Plan admin contact email address	
Plan admin contact street address	
Plan admin contact city	
Plan admin contact state (abbreviation)	
Plan admin contact ZIP	
Plan year	
Plan start date (01/01/25 format)	
Plan end date (12/31/25 format)	
Is the health plan an individual market policy or a nonfederal government plan?	☐ Yes ☐ No
Is the health plan grandfathered under the ACA (notice on page 10)?	☐ Yes ☐ No
Are you a state or local government employer sponsoring a self-funded health plan, *and* have been approved for the HIPAA opt-out exemption (**not common**; notice on page 11)? **If yes**, answer the following questions:	☐ Yes ☐ No
Does the exemption include 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?	☐ Yes ☐ No
Does the exemption include certain requirements to provide benefits for breast reconstruction after a mastectomy?	☐ Yes ☐ No
Does the exemption include 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 and who takes a medically necessary leave of absence from a postsecondary educational institution?	☐ Yes ☐ No
Do you sponsor a prescription drug plan? **If yes**, complete the following:	☐ Yes ☐ No
Provide the name of the prescription drug plan.	

Is the prescription drug coverage **creditable coverage** (notice on page 22)? **If yes**, complete the following:	☐ Yes	☐ No
Is coverage affected if the employee chooses a Medicare drug plan?	☐ Yes	☐ No
Describe 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).		
Will dependents be able to get coverage back if the employee joins a Medicare drug plan?	☐ Yes	☐ No
If prescription drug coverage is **not creditable** (notice on page 24), complete the following:		
Was the most recent, previous coverage provided creditable?	☐ Yes	☐ No
Will the coverage be affected if the employee chooses a Medicare drug plan?	☐ Yes	☐ No
Describe 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).		
Will dependents be able to get coverage back if the employee joins a Medicare drug plan?	☐ Yes	☐ No
Do you provide a voluntary wellness program (notices on pages 30–33)? **If yes**, complete the following:	☐ Yes	☐ No
What is the wellness program's name?		
Does the wellness program include biometric screenings?	☐ Yes	☐ No
If yes, will the biometric screening results be used to offer employees other services through the program?	☐ Yes	☐ No
Describe the other services that may be offered.		
Does the wellness program include blood tests?	☐ Yes	☐ No
If yes, describe the specific conditions for which the blood will be tested.		
Does the wellness program include additional incentives for participating in certain health-related activities? **If yes**, answer the following questions:	☐ Yes	☐ No
Describe the incentives.		
Describe the specific activities.		
Describe specific health outcome achievements.		
Is your group health plan (e.g., medical, dental, vision) subject to federal COBRA continuation laws for employers with 20 or more employees (notice on page 17)? **If yes**, complete the following information:	☐ Yes	☐ No
If you sponsor a group health plan, are COBRA coverage premiums paid for by the COBRA beneficiary?	☐ Yes	☐ No
Does the group health plan provide retiree coverage?	☐ Yes	☐ No
Enter the number of days to notify the plan administrator of a COBRA qualifying event (60 days is the minimum required number of days).		
Enter the first and last name of the person to whom an employee must provide notice of their qualifying event (either at the business or third-party administrator).		

Enter the mailing address of the person to whom an employee must provide notice of their qualifying event (either at the business or third-party administrator).		
Enter the phone number of the person to whom an employee must provide notice of their qualifying event (either at the business or third-party administrator).		
Describe any additional plan procedures for providing the qualifying event notice to the plan administrator, including a description of any required information or documentation.		
Describe any additional plan procedures for providing the Social Security disability 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.		
If you sponsor a group health plan (notice on page 28), complete the following information:		
Does the group health plan **allow** the designation of a primary care provider (PCP) by participants or beneficiaries?	☐ Yes	☐ No
Does the group health plan **require** the designation of a primary care provider (PCP) by participants or beneficiaries?	☐ Yes	☐ No
Does the group health plan **allow** the designation of a primary care provider (PCP) for children?	☐ Yes	☐ No
Does the group health plan **require** the designation of a primary care provider (PCP) for children?	☐ Yes	☐ No
If a PCP is allowed or required, does the plan or insurer automatically designate a PCP?	☐ Yes	☐ No
If the plan provides coverage for obstetric or gynecological care, does it require the designation of a PCP?	☐ Yes	☐ No
What is the name of the group health plan insurer (if the plan is self-funded, provide the employer's name)?		

Clear All Boxes

Notices Chart

Notice	Employer Size	When to Use the Notice
Disclosure of Grandfathered Plan Status	All	Use this notice only for a group health plan that maintains grandfathered plan status, as defined by the Affordable Care Act (ACA).
Disclosure to Enrollees Regarding HIPAA Opt-Out	All	Use this notice only for a self-funded nonfederal governmental plan that has opted out of certain federal benefit mandates, such as coverage for reconstructive surgery following mastectomies. This is uncommon.
Employer CHIP Notice* *The notice in this packet is the current notice, but links may not be accurate. If EBSA provides an updated notice with accurate links, we'll replace this version.	All	Use this notice if group health coverage is offered to persons who live in any one of the states listed in the notice. For convenience, this notice may be distributed to all persons eligible for group health coverage, regardless of location. Do not attach this notice to other material. It must stand alone.
General Notice of COBRA Rights Spanish Notice	20+	Use this notice for new group health plan enrollees. **Caution:** Most employers use an outside COBRA administrator. In that case, consult with vendor to determine whether to use this template or the vendor's customized notice.
General Notice of FMLA Rights Spanish Notice	50+	Requirement to provide this notice can be met either by distributing it to FMLA-eligible employees, or by simply including the text in employee handbooks. In either case, the employer must display this FMLA Notice (as a poster) in the workplace.
General Notice of USERRA Rights	All	This notice is **optional**. Although employers are required to display this USERRA Notice (as a poster) in the workplace, they are not required to distribute it to employees.
Medicare Part D Notice of Creditable Coverage Disclosure Notice	All	Use this notice only if the group health plan's prescription drug coverage is creditable (i.e., equal or superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare-eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is creditable, include this notice and identify the creditable plan.
Medicare Part D Notice of Non-Creditable Coverage Disclosure Notice	All	Use this notice only if the group health plan's prescription drug coverage is non-creditable (i.e., is not equal nor superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare-eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is non-creditable, include this notice and identify the creditable plan.
Michelle's Law Sample Notice	All	Use this notice for a group medical plan that provides dependent coverage beyond age 26 with student status when a dependent child experiences a medically necessary leave of absence from school. Separate distribution is not required if the information in the notice already appears in the plan's Summary Plan Description (SPD).
Newborns' and Mothers' Health Protection Act Notice	All	Use this notice (page 140) for a group medical plan that includes maternity and newborn coverage. Separate distribution is not required if the information in the notice already appears in the plan's SPD.

Notice	Employer Size	When to Use the Notice
Patient Protection Model Notice	All	Use this notice for nongrandfathered health plans that allow or require members to designate primary care physicians (PCPs) and/or require preauthorization or referral for other care. Separate distribution is not required if the information already appears in the plan's SPD.
Benefits Special Enrollment Rights Notice	All	Use this notice for all group health plans (other than "excepted benefits" such as a standalone dental or vision plan, or health FSA, that has not adopted HIPAA's special enrollment rules).
Section 125 Cafeteria Plan	All	Section 125 plan documents must be created and adopted for compliance with Internal Revenue Code § 125 when withholding pre-tax benefits contributions. An SPD must be distributed to employees when a health flexible spending or dependent care account is included in a cafeteria plan.
Summary Plan Description (SPD)	All	An SPD must be created and distributed within 90 days of enrollment.
Summary of Benefits and Coverage (SBC), Uniform Glossary	All	SBCs may be obtained from the insurance carrier and must be provided. A sample SBC template is available, if needed. The Uniform Glossary must also be provided.
Wellness Program Disclosure (ADA)	15+	Use this notice for a wellness program that is subject to the Americans with Disabilities Act (ADA) regarding programs that request health information.
Wellness Program Disclosure Notice (GINA)	15+	Use this notice for a wellness program that requests any health information. Employers are prohibited from requesting or requiring genetic information. By providing this notice, any receipt of genetic information generally will be deemed inadvertent and not a violation of the prohibition.
Wellness Program Disclosure Notice (HIPAA)	All	Use this notice (page 139) for a wellness program that is subject to HIPAA's notice requirement regarding reasonable alternative standards to earn a program incentive.
Women's Health and Cancer Rights Act Notice	All	Use this notice (page 141 for enrollment notice and page 142 for annual notice) for group medical plans that cover mastectomies.

This content is owned and provided by Mineral, Inc. "AS IS," and is intended for informational purposes only. It does not constitute legal, accounting, or tax advice, nor does it create an attorney-client relationship. Because laws are constantly changing, we do not represent or warranty that the content is comprehensive of all applicable laws and regulations, and/or accurate as of the date of use. You are solely responsible for complying with all applicable laws and regulations. Mineral expressly disclaims any liability associated with your use of the content, and/or your noncompliance with applicable laws and regulations.

Notices

Disclosure of Grandfathered Plan Status	10
Disclosure to Enrollees Regarding HIPAA Opt-Out	11
Premium Assistance Under Medicaid and CHIP	12
General Notice of COBRA Rights (continuation coverage rights)	17
Your Employee Rights Under the FMLA	20
Your Rights Under USERRA	21
Important Notice About Your Prescription Drug Coverage and Medicare (creditable)	22
Important Notice About Your Prescription Drug Coverage and Medicare (non-creditable)	24
Michelle's Law Notice	26
Newborns' and Mothers' Health Protection Act Notice	27
Notice of Patient Protections (PCPs)	28
Notice of Special Enrollment Rights	29
Wellness Program Disclosure (GINA)	30
Notice Regarding Wellness Program (ADA)	31
Wellness Program Disclosure (HIPAA)	33
Women's Health and Cancer Rights Act	34

Disclosure of Grandfathered Plan Status

Plan name:

The plan named above is believed to be 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 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:

Plan contact name:

Plan contact phone number:

Plan contact email address:

The following are applicable to the plan only if checked:

- ☐ ERISA Plans: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or the U.S. Department of Health and Human Services at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers.
- ☐ Individual market policies and nonfederal governmental employer plans: You may also contact the Department of Health and Human Services at https://www.hhs.gov/.

☐ *Include*

Disclosure to Enrollees Regarding HIPAA 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. We have elected to exempt the plan from the requirements checked below:

- ☐ 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.
- ☐ Certain requirements to provide benefits for breast reconstruction after a mastectomy.
- ☐ 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 beginning on and ending on .

The election may be renewed for subsequent plan years.

Per the Genetic Information Nondiscrimination Act (GINA), the opt-out does not prevent the Health Insurance Portability and Accountability Act (HIPAA) 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.

☐ *Include*

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 5/31/2029)

General Notice of COBRA Rights from 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 are required to pay for COBRA continuation coverage. ☐ Yes ☐ No

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."

☐ *Include (if 20+ employees)*

☐ If checked, the Plan provides retiree coverage, and the following applies:

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 the business named above, 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;
- If retiree coverage is checked above, 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 days after the qualifying event occurs. You must provide this notice to:

Name:

A description of any additional plan procedures will be included below if applicable.

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. If applicable, a description of any additional plan procedures for providing this notice will be displayed below.

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, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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. (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.

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

[1] https://www.medicare.gov/sign-up-change-plans

☐ *Include*

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — May 2022

OMB 0938-0990

Important Notice About Your Prescription Drug Coverage and Medicare Form

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

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

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

Plan name:

When Can You Join A Medicare Drug Plan?

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

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 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 employer-sponsored coverage ☐ will ☐ will not be affected. 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 includes:

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

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

☐ *Include*

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 employer-sponsored coverage with 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 19 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. **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 your employer-sponsored coverage through changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare 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).

Notice date:

Employer name:

Address:

Contact name:

Phone number:

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

Important Notice About Your Prescription Drug Coverage and Medicare Form

Please read this notice carefully and keep it where you can find it. This notice has information about your current employer-sponsored prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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 three important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. Your employer has determined that the prescription drug coverage offered by the Plan named below 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 plan named below. 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 employer-sponsored coverage. 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.

Plan name:

When Can You Join A Medicare Drug Plan?

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

However, if you decide to drop your current employer-sponsored coverage, 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 the plan named above.

The following statement applies if checked: ☐

Since you are losing creditable prescription drug coverage under your employer-sponsored plan, you are also eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under your employer-sponsored 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 19 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.

☐ *Include*

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 employer-sponsored coverage ☐ will ☐ will not be affected. 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 includes:

If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, be aware that you and your dependents ☐ will ☐ 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 employer-sponsored coverage with 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 19 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. **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 your employer-sponsored coverage through changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Notice date:

Employer name:

Address:

Contact name:

Phone number:

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Michelle's Law Notice

Michelle's Law is a federal law passed in 2008 that extends coverage for a dependent child over the age of 26 when enrolled as a full-time student in post-secondary education prior to a medically necessary leave of absence suffered by the child, which causes the loss of full-time student status.

The group health plan of the employer named above includes eligibility of coverage for an employee's dependent child, defined as an employee's eligible dependent child under Code § 152(f)(1), who is over the age of 26, pursuant to a state-mandated benefit that requires a full-tme student status in a post-secondary educational institution and who would otherwise lose health coverage because they take a medically necessary leave of absence that would cause the loss of full-time student status, may be entitled to up to one year of continued coverage due to the medically necessary leave.

To be eligible for this extension, the dependent child's treating physician must provide a written certification to the plan administrator that the child is suffering from a serious illness or injury and the leave of absence from the post-secondary institution is medically necessary.

A child on a medically necessary leave of absence is entitled to receive the same plan benefits as other dependent children covered under the plan. Any change to plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other children covered under the plan.

Newborns’ and Mothers’ Health Protection Act Notice

Plan name:

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).

Notice of Patient Protections (PCPs)

The group health plan named above generally ☐ requires ☐ allows the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members.

If checked below, the plan or health insurance coverage designates a PCP automatically:

☐ Until you make this designation, the group health plan named above designates one for you. For information on how to select a PCP, and for a list of the participating PCPs, contact the plan administrator listed below.

The plan ☐ requires ☐ allows for the designation of a PCP for a child. If either option is checked, you may designate a pediatrician as the PCP for a child.

If checked below, the plan provides coverage for obstetric or gynecological care and requires the designation by a participant or beneficiary of a PCP:

☐ You do not need prior authorization from the group health plan named above or from any other person (including a PCP) 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 healthcare professionals who specialize in obstetrics or gynecology, contact the plan administrator listed below.

Plan administrator contact information:

☐ *Include*

Notice of Special Enrollment Rights

Plan name:

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 30 days (or any longer period stated in the Plan Document) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days (or any longer period stated in the Plan Documents) 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 60 days, (or any longer period stated in the Plan Document) 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 60 days, (or any longer period stated in the Plan Document) after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan administrator:

Wellness Program Disclosure (GINA)

Plan name:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ***Genetic information*** as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

☐ *Include*

Notice Regarding Wellness Program (ADA)

The wellness program named above 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, and ☐ a blood test for the following conditions (if checked):

You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Employees who choose to participate in the wellness program ☐ will receive an incentive (if checked) based on certain criteria:

Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the named incentives.

If applicable, additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes as follows:

☐ *Include*

If you cannot participate in any of the health-related activities or perform 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 the plan administrator listed below.

If applicable, the information from your HRA and the results from your biometric screening will provide information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, as listed below, and you are also encouraged to share your results or concerns with your 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 your employer named above may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program listed above 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 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 to provide 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 are listed in the program's documents (e.g., a licensed healthcare provider or a health coach) 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. Appropriate precautions will be taken to avoid any data breach. We will notify you immediately if a data breach occurs involving information you provide in connection with the wellness program.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program. You will not be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice or protections against discrimination and retaliation, please contact the plan administrator:

Wellness Program Disclosure (HIPAA)

Plan name:

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 the plan administrator listed below 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.

☐ *Include*

Women’s Health and Cancer Rights Act

Plan name:

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. Deductibles and coinsurance values are listed in the health plan’s Summary of Benefits and Coverage document.

If you would like more information on WHCRA benefits, contact the plan administrator: