MICHIGAN IMPORTANT NOTICES

STATE & FEDERAL DISCLOSURES

2024 / 2025

MICHIGAN PLANNERS

BIG ENOUGH TO SERVE,
SMALL ENOUGH TO CARE.™

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About this Booklet

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

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

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

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GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions prohibiting the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers. and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Privacy Overview and Notice

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

WHAT INFORMATION IS PROTECTED BY HIPAA PRIVACY RULES?

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

RIGHTS OF INDIVIDUALS

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

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

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

"We," "Us," and "Plan" refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to the entity stated in your Summary Plan Description or other plan documents. ''You" or "yours" refers to individual participants in the Plans.
PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

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

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

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

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:
- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
- Abide by the terms of this Notice as it may be updated from time to time.

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

PRIMARY USES AND DISCLOSURES OF PHI

The main reasons for which we may use and may disclose your PHI are to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.
The following describe these and other uses and disclosures together with some examples:

Treatment*:

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

Payment*:

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

Health Care Operations Purposes*:

1. We may use your PHI or disclose it to others for quality assessment and improvement activities.
2. We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.
3. We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.
4. We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, performance of health care providers, or conducting training programs.
5. We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.
6. We may use your PHI or disclose it to others in the process of contracting health benefits or insurance covering health care costs.
7. We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.
8. We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.
9. We will not use or disclose your genetic information for underwriting.

Business Associates:

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

Plan Sponsor:

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

Other Covered Entities:

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

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

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

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

Regarding Abuse, Neglect, or Domestic Violence:

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

To Persons Involved in Care and for Notification Purposes:

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

Regarding Coroners, Medical Examiners, and Funeral Directors:

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

For Public Health Activities:

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

To Avert a Threat to Health or Safety:

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

Organ and Tissue Donations:

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

New Privacy Protections for Reproductive Health – effective Dec. 2024

HHS published a final rule that strengthens the HIPAA Privacy Rule by prohibiting the disclosure of protected health information (PHI) related to **lawful reproductive health care** in certain situations. The Rule sets strict limits on the use, disclosure and protection of PHI by covered entities.

The new protections prohibit regulated entities from using or disclosing PHI related to lawful reproductive health care:

- For a criminal, civil or administrative investigation into (or proceeding against) a person in connection with reproductive health care; or
- To identify an individual, health care provider or other person for purposes related to such an investigation or proceeding.

Regulated entities must presume that reproductive health care provided by another entity was lawful unless they have actual knowledge that the care was unlawful or factual information from the person requesting the use or disclosure of PHI that demonstrates the care was unlawful.

Attestation Requirement:

A regulated entity must obtain a **valid attestation** before it uses or discloses PHI potentially related to reproductive health care for certain purposes, such as health oversight activities, judicial and administrative proceedings, law enforcement purposes, or disclosures to coroners or medical examiners. The attestation is used to verify that the requested use or disclosure of PHI complies with the new privacy protections and is not for a prohibited purpose. For an attestation to be valid, it must be a standalone document that includes certain information such as a clear statement that the use or disclosure is not for a prohibited purpose.

MICHELLE'S LAW

"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

NEWBORNS and MOTHERS HEALTH PROTECTION ACT DISCLOSURE

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

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver your baby in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission.

If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the 48-hour (or 96-hour) period, the group health plan or health insurance issuer does not have to continue covering the stay for the one ready for discharge. A health plan, hospital, insurance company, or HMO would NOT be an attending provider.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.
If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

WHCRA requires group health plans and health insurance companies (including HMOs), to notify individuals regarding coverage required under the law. Notice about the availability of these mastectomy-related benefits must be given:

1. To participants and beneficiaries of a group health plan at the time of enrollment, and to policyholders at the time an individual health insurance policy is issued; and
2. Annually to group health plan participants and beneficiaries, and to policyholders of individual policies.

WHCRA does NOT require group health plans or health insurance issuers to cover mastectomies in general. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is subject to WHCRA requirements.

SOCIAL SECURITY NUMBER PRIVACY ACT

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

MICHIGAN'S ABORTION OPT-OUT ACT

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

The State of Michigan Public Act 182 of 2013, titled Abortion Insurance Opt-Out Act, requires the purchase of coverage for elective abortion in a health care plan to be by an optional rider only which carries an additional premiums for inclusion of this coverage; requires notice to employees for whom elective (as defined by MVL 550.551) abortion coverage is purchased by their employer; and provides penalties for violations of this Act. The following notice is intended to fully comply with the employer mandate in MCL 550.554, and hereby notifies each employee: Elective abortions (as defined by MCL 550.551) will be included as a rider to your group health plan coverage and this group health coverage may be used by a covered dependent without notice to the employee.

WELLNESS PROGRAM DISCLOSURE

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

WELLNESS NOTICES:

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

program requests family or genetic information, written authorization is required by employees and spouses, and it must indicate the genetic
information obtained, how it will be used and any restrictions on its disclosure. This information must be communicated in a GINA Wellness Disclosure*. Recommendations of an individual's personal physician will be accommodated.

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

PATIENT PROTECTIONS NOTICE

If a qualifying benefit option under a group health plan maintained by the employer generally requires or allows the designation of a primary care provider, the covered individual has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the covered individual. Until the covered individual makes this designation, the Plan may designate a primary care provider for him/her. For children, the covered employee or spouse may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HR Department or the insurance carrier.

For any qualifying benefit option, covered individuals do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HR Department or the insurance carrier.

MEDICARE SECONDARY PAYER MANDATORY REPORTING

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

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

MEDICARE PART D
Creditable or Non-Creditable Coverage Notice Overview

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

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

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

NOTICE OF YOUR MEDICARE PART D CREDITABLE COVERAGE STATUS

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

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

SPECIAL ENROLLMENT NOTICE

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

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

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

SUMMARY OF BENEFITS & COVERAGE (SBC)

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

Other times an SBC must be provided:
- Upon application (i.e., when you are initially eligible for coverage);
- By the first day of coverage
- When an event triggers HIPAA special enrollment rights; and
- Within 7 business days upon request.

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

NO SURPRISES ACT

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 balanced 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 can 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 types of 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.

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

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

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the U.S Centers for Medicare & Medicaid Services (CMS). The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit www.michigan.gov/difs for more information about your rights under Michigan laws. The Department of Insurance and Financial Services responsible for the Michigan version of the law can be contacted at 1-877-999-6442.

COBRA CONTINUATION COVERAGE

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

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

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

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

WHAT IS COBRA CONTINUATION HEALTH COVERAGE?*

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

WHAT DOES COBRA DO?*

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

WHICH EMPLOYERS ARE REQUIRED TO OFFER COBRA COVERAGE?*

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

UNDER COBRA, WHAT BENEFITS MUST BE COVERED?*

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

WHO CAN ANSWER OTHER COBRA QUESTIONS?*

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

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

FAMILY & MEDICAL LEAVE ACT OF 1993

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

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

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

LEAVE ENTITLEMENTS

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

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

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

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

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

BENEFITS & PROTECTIONS

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

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

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

ELIGIBILITY REQUIREMENTS

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

- Have worked for the employer for at least 12 months (which need not be consecutive);
- Have at least 1,250 hours of service in the 12 months before taking the first day of the requested leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

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

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

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

EMPLOYER RESPONSIBILITIES

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

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

ENFORCEMENT

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

MENTAL HEALTH PARITY and ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally prevents group health plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Under MHPAEA, the financial requirements (such as deductibles and co-pays) and treatment limitations applicable to MH/SUD benefits cannot be more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. MHPAEA's parity requirements apply to both number of visits as well as medical management standards.

MHPAEA generally applies to employers with 50 or more employees. However, ACA builds on MHPAEA and requires some plans to cover MH/SUD services as an essential health benefit. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements.

Parity Requirements

MHPAEA contains the following parity requirements:

- The financial requirements (such as copays, deductibles, out-of-pocket maximums) that apply to the MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to the medical and surgical benefits.

- Treatment limitations (frequency of treatment, number of visits, length of coverage) cannot be more restrictive on MH/SUD than those applied to other medical benefits.

Other benefits that MHPAEA imposes parity requirements on include medical management standards, formulary designs for prescription drugs, methods for determining reasonable and customary charges, exclusions based on a failure to complete a course of treatment and restrictions based on facility type or provider specialty.

MHPAEA requires comparative analysis to ensure plans are compliant. In most cases, carriers will help prepare comparative analyses for employer-sponsored health plans. However, the final rule requires the comparative analyses for ERISA-covered plans to also include a plan fiduciary's certification that they have engaged in a prudent process and monitored their service provider(s).

Disclosure Requirements

MHPAEA requires plans to make information available to participants with respect to MH/SUD benefits regarding the criteria for medical necessity and reason for claim denial(s). In addition, upon request, ERISA plans must provide participants with information about processes, strategies, evidentiary standards, and other factors used to determine compliance with MHPAEA. To avoid penalties, employers should respond to these requests within 30 days.

Fixed Indemnity Excepted Benefits Consumer Notice

Excepted benefits are exempt from certain federal consumer protections, including certain ACA mandates, such as required coverage for preventative care, prohibition of lifetime and annual dollar limits on essential health benefits, prohibition of preexisting condition exclusions, and waiting period limits.

Hospital indemnity or other fixed indemnity insurance are considered “excepted” benefits under federal regulations if all the following conditions are met:

1. The benefits are provided under a separate policy, certificate, or contract of insurance.
2. There is no coordination between the fixed indemnity benefits and any exclusion under any group health plan maintained by the same employer plan sponsor; and
3. The benefits are paid for an event without regard to whether benefits are provided for such event under any group health plan maintained by the same employer plan sponsor.

Additionally, under existing regulations, hospital indemnity and other fixed indemnity insurance in the group market must pay a fixed dollar amount per day (or other period) of hospitalization or illness, regardless of the amount of expenses incurred, to be considered an excepted benefit.

This notice applies to new and existing indemnity coverage that pay a per day (or other period) benefit as opposed to a lump sum for services or diagnosis.

The notice must be provided at the time or before participants have the chance to enroll or re-enroll in benefits.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **800-318-2596** (TTY: 855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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).

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.

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 January 31, 2024. 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	INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 January 31, 2024, 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 1/31/2026)

To see if any other states have added a premium assistance program since July 31, 2023, 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

GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

This glossary defines many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document).

Allowed Amount: This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

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

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

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

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay

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

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

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

Cost-sharing Reductions: Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a

coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

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

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

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

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

Emergency Medical Transportation: Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

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

Grievance: A complaint that you communicate to your health insurer or plan.

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

Health Insurance: A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

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

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

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an

plan may not cover all types of emergency medical transportation or may pay less for certain types.

Emergency Room Care/Emergency Services: Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services: Health care services that your plan doesn't pay for or cover.

In-Network Coinsurance: Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

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

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

Maximum Out-of-pocket Limit: Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher

overnight stay for observation as outpatient care instead of inpatient care.

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

Minimum Value Standard: A basic standard to measure the percentage of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value, and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider): A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

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

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

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

Out-of-network Provider (Non-Preferred Provider): A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network

than the out-of-pocket limits stated for your plan.

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

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

Out-of-pocket Limit: The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

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

Plan: Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization

services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

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

Prescription Drugs: Drugs and medications that by law require a prescription.

Preventative Care (Preventative Service): Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

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

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

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

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

for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

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

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

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

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

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

Specialist: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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