



2015-2016

Important Notices

Important Notices

(No Action Required)

Newborns' and Mothers' Health Protection Act (NMHPA)

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).

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan. Proof of Student Status must be provided to certify student status for plan coverage.

Family Medical Leave Act of 1993

You are eligible for leave under the Family and Medical Leave Act (FMLA) if you have been employed for a total of 12 months and worked at least 1,250 hours during the 12 months preceding the leave.

Eligible employees will receive up to 12 weeks of leave within any rolling 12-month period for the birth or adoption of a child, for the employee's own serious health condition, or to care for a child, spouse or parent with a serious health condition.

Eligible employees may also be eligible for FMLA leave to care for a family member who is a member of the Armed Forces under certain circumstances.

Women's Health and Cancer Rights Act (WHCRA)

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.

USERRA

Under the Uniformed Services Employment Reemployment Rights Act of 1994 (USERRA), employees are provided with broad protection in terms of their reemployment upon completion of military service. An employee, who returns to work after active military duty must, with limited exceptions, be reemployed in the position that the employee held or would have attained had the military service not interrupted the employee's employment.

The Act provides specific time frames in which the employee must return to work upon completion of service. If the length of service was less than 31 days, the employee must return the next regularly scheduled work period. If the leave was greater than 31 days and less than 180 days, the employee has 14 days upon completion to return to work. The company will comply with all aspects of USERRA.

Genetic Information Nondiscrimination Act 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Our Plan complies with these requirements.

Important Notices

(No Action Required)

Patient Protection Model Disclosure

Group Health Plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Group Health Plan at the number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Group Health Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Group Health Plan.

Notice of Adverse Benefit Determination

Employer-sponsored group health plans are required to provide notice of an adverse benefit determination when a claim is first denied.

- In the case of a claim filed before medical services are provided, notice of the adverse benefit determination within 30 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits) the notice of adverse benefit determination with respect to a non-urgent claim is required within 15 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- If the pre-service claim is for urgent care, the notice of adverse benefit determination generally is required within 24 hours of filing.

These timing rules are currently in effect for ERISA plans, except that the 24-hour deadline for urgent pre-service claims will become effective for plan years starting on or after September 23, 2010 (currently the requirement generally is to provide the notice within 72 hours). Available at: <http://www.dol.gov/ebsa/IABDModeiNotice2.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModeiNotice2sp.doc>.

Notice of Final Internal Adverse Benefit Determination

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to provide notice of a final internal adverse benefit determination when internal appeals procedures have been completed. This notice is similar to the notice of decision on appeal that is currently required of ERISA plans under DOL regulations. If a plan has only one level of appeal, the final internal adverse benefit determination is the only notice of the decision on appeal that is required (provided it also meets applicable ERISA requirements). Plans may have one or two levels of internal appeals and, if a plan has two appeal levels, this model notice is intended for use only after the second internal appeal if it results in an adverse benefit determination.

- In the case of a claim filed after medical services are provided, this notice is required within 60 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits), the notice of final internal adverse benefit determination with respect to a non-urgent claim is required within 30 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- If the pre-service claim is for urgent care, the notice of final internal adverse benefit determination generally is required within 72 hours after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

These timing rules are the same as those currently in effect for ERISA plans. Available at: <http://www.dol.gov/ebsa/IABDModeiNotice1.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModeiNotice1sp.doc>.

Notice of Final External Review Decision

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to maintain an external review procedure that meets certain requirements, including a notice of final decision. The agencies have provided a model notice for that purpose. Available at: <http://www.dol.gov/ebsa/IABDModeiNotice3.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModeiNotice3sp.doc>.

Important Notices for 2015

(No Action Required)

Special Enrollment Notice

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing 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 after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SGHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

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

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

(No Action Required)

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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

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

(No Action Required)

<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: www.ohhs.ri.gov Phone: 401-462-5300</p>

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

(No Action Required)

<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/medicaid/premiumpynt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center">UTAH – Medicaid and CHIP</p> <p>Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414</p>	<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531</p>

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)



2015-2016

Important Notices

Not all plan provisions, limitations, and exclusions are included in this publication. In the event of any conflict between the information contained in this publication and the plan provisions, the Plan Documents and insurance contracts will govern. Copies of those documents are available from Human Resources for your inspection during normal business hours.