



consulting
group

EMPLOYEE BENEFITS 2016 PLAN YEAR

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BENEFITS DIRECTORY













BENEFIT ADVISORS		
Ball*Peoples	1-888-478-9595 Austin: 512-478-9595 Fax: 512-478-9494	600 W. 5 th St, Suite 200 Austin, TX 78701 www.ballpeoples.com
Account Manager:		
Katie Seaman		katie@ballpeoples.com
MEDICAL		
HUMANA	1-866-427-7478	www.myhumana.com
Policy #681242		Claims:
Network:		Humana Claims
National POS-Open Access		P.O. Box 14610
		Lexington, KT 40512
PRESCRIPTION DRUG		
Right Source Rx	1-800-379-0092 Specialty Drugs: 1-800-486-2668	www.rightsourcerx.com P.O. Box 745009 Cincinnati, OH 45274-5099
DENTAL		
Dental Select	1-800-999-9789	5373 S. Green St. 4 th Floor Salt Lake City, UT 84123 www.dentalselect.com
Policy #: 12003124		
Network:		
Platinum Co-Insurance		
VISION		
Dental Select	1-800-999-9789	5373 S. Green St. 4 th Floor Salt Lake City, UT 84123 www.dentalselect.com
Policy #: 12003124		
Network:		
Access Vision- EyeMed		
LIFE		
Lincoln Financial	1-800-423-2765	P.O. Box 2649 Omaha, NE 68103-2649 www.Lincoln4benefits.com
Policy #: 940146107		

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This summary is not an insurance contract. This summary was compiled by employees of Ball*Peoples. Changes, omissions or oversights are possible. Please refer to the actual carrier policy for a full description of benefits.

WELCOME

The Neos Consulting Group benefit program you receive while you are an employee of our company is administered by Ball*Peoples Benefits Group. Our dedicated Account Manager is Katie Seaman. Please contact our Account Manager for any escalated or urgent issues.

Your benefit enrollment is very important. Please review the following guidelines to assist you in submitting the appropriate forms and documentation to enroll in the benefit plans offered. Timely submission of your forms will ensure coverage for you and your family members. We urge you to keep this handbook and refer to it when you have questions about your benefits. Should you have any questions or need assistance, please contact Lori Trank at 512-431-3843.

Obtaining Services before you get your Benefit ID Cards

If you change medical plans/carriers during open enrollment or you are a new hire who does not submit their enrollment paperwork in a timely manner, you may not receive your ID card prior to the effective date of your benefits. Until you receive your ID card, you may have to pay for services in full and get reimbursed by the carriers after you have your enrollment information. Be sure to save all of your receipts and contact your HR Department for more information on how to file carrier claims manually for reimbursement.

PLAN ELIGIBILITY

All full-time employees working at least 30 hours per week are eligible to enroll in the insurance benefits provided by Longhorn Title. Employees regarded as part-time or temporary are not eligible for benefits.

Benefits are effective on the first of the month following full-time date of hire.

Enrollment is not automatic. Participation cannot begin without completion of the required enrollment materials.

IF YOU ARE A NEW EMPLOYEE:

You are required to complete and return all enrollment materials within 30 days of your date of hire to ensure that you are enrolled in a timely manner and have access to the benefits on the first day they are effective.

IF YOU ARE A CURRENT EMPLOYEE:

You may begin, stop, or change your coverage elections as a result of a qualified life status change as defined by Section 125 of the Internal Revenue Code and allowed by this plan. Medical plan changes are **NOT** allowed until the next open enrollment period without a qualifying life status change. See the “Qualifying Life Events” section for a complete list.

DEPENDENT ELIGIBILITY

You can enroll dependents on applicable benefit plans. Eligible dependents include:

- Your legal spouse
- Your domestic partner (must complete notarized Affidavit of Domestic Partnership)
- A child under the plan limiting age (26 for medical)
 - *Child* means a natural child, a stepchild, an adopted child, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors.
- Any child of any age who is medically certified as Disabled and dependent on the parent
- A child of your child who is your Dependent for federal income tax purposes at the time application for coverage is made
- A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage, and who is dependent upon you for more than one-half of their support as defined by the US Internal Revenue Code.

INELIGIBLE DEPENDENTS:

Please review the eligibility requirements described above. Any ineligible dependents must be removed from your coverage as soon as they become ineligible. Here are examples of some ineligible dependents:

- Anyone who is not your legal spouse or child as defined above
- Dependents no longer covered by a court order
- Dependent child(ren) with coverage available through another employer group

QUALIFYING LIFE EVENTS

You have **30 days** from the date of any qualified life status change to notify your HR Department and complete any applicable change forms. If you do not make your eligible changes during the 30-day change period, your changes **CANNOT** be made until the next Annual Open Enrollment period. The list below includes some common examples of qualified life events:

- Marriage
- New baby – coverage will be effective as of the date of birth
- Divorce
- Employment status change – part-time to full-time
- Loss or gain of other coverage – coverage will be effective on the first of the month following the last day of your previous coverage
- Child turns age 26

MEDICAL INSURANCE



When visiting a facility or physician that is in-network you will have significantly lower costs than an out of network facility or physician. The explanation of medical benefits below is meant to cover the more common uses of the insurance and how the plan would pay at in-network providers. For a more detailed explanation of your benefits; including out of network benefits, refer to the additional carrier information found online via the Humana portal.

	\$1,000-80% OPT 10	\$2,000-80% OPT 12
	Your Cost at In-Network Providers	Your Cost at In-Network Providers
<i>LIFETIME MAXIMUM</i>	Unlimited	Unlimited
<i>OFFICE VISITS</i>		
<i>Primary Care</i>	\$25 Copay	\$40 Copay
<i>Specialist</i>	\$40 Copay	\$75 Copay
<i>Urgent Care</i>	\$100 Copay	\$100 Copay
<i>Preventive Care</i>	No Charge	No Charge
<i>DEDUCTIBLE</i>		
<i>Individual</i>	\$1,000	\$2,000
<i>Family</i>	\$2,000	\$4,000
<i>OUT-OF-POCKET MAXIMUM</i>	*Includes Deductible*	*Includes Deductible*
<i>Individual</i>	\$4,000	\$6,350
<i>Family</i>	\$8,000	\$13,000
<i>HOSPITAL/EMERGENCY ROOM</i>		
<i>Inpatient Services</i>	20% after Deductible	20% after Deductible
<i>Emergency Room</i>	20% after \$400 Copay	20% after \$500 Copay
<i>OUTPATIENT</i>		
<i>Outpatient Surgery</i>	20% after Deductible	20% after Deductible
<i>Outpatient Services (CT Scan, MRI, PET Scan)</i>	20% after Deductible	20% after Deductible
<i>PRESCRIPTION DRUGS</i>		
<i>Level 1</i>	\$10 Copay	\$10 Copay
<i>Level 2</i>	\$30 Copay	\$45 Copay
<i>Level 3</i>	\$50 Copay	\$75 Copay
<i>Level 4</i>	25% Co-Insurance	25% Co-Insurance
<i>Mail Order</i>	2.5 x Copay for 90 days	2.5 x Copay for 90 days

WAIVING MEDICAL COVERAGE

You may decide that you do not want medical coverage with us. In the event that you waive coverage, you cannot enroll in this health plan unless you experience a qualifying life status change or during the next open enrollment period

TRANSITIONING TO THE PLAN

If you are moving from another carrier, you will need to notify your doctors and pharmacy of your new carrier as well as policy and ID number. Please ensure that your doctors are in the new carrier network and that your prescriptions are on the formulary list. See the carrier website for more information. You will receive an ID card in the mail in 7-10 business days after implementation is complete.

PAYING FOR YOUR MEDICAL BENEFITS

Your employer makes a significant investment in your medical benefits by paying 100% of the employee only cost for the \$2,000-80% OPT 11 Plan. You are responsible for any dependent cost through payroll deductions. Medical deductions are based on your effective date and any retroactive changes will be collected from the next available paycheck. Please see Rate Sheet for plan pricing. Please be sure to regularly review your payroll deductions to ensure accuracy

Registration on carrier website:

We highly recommend that you register as a member with all carriers to gain access to additional benefit information as well as perks for being a member. You will need to have your ID card handy when registering.

1. Visit www.myhumana.com
2. Select "Register"
3. Select "Register Now"
4. Choose "Members"

PRESCRIPTION DRUG INFORMATION

For more information on how prescription drugs are covered, please visit the Humana Pharmacy website at www.humanapharmacy.com. You will need to click on "search by drug name" to see how your prescription is covered. If your medications are not on the formulary list, you may need to talk to your doctor about switching to an equivalent drug or filing an appeal.

VOLUNTARY DENTAL INSURANCE



All eligible employees have the option to enroll in the comprehensive dental plan offered through Dental Select. This benefit is a voluntary benefit and paid 100% by the employee. You are responsible for all employee and dependent cost through payroll deductions.

Dental Select does issue dental ID Cards to members. Dependents will be listed on the member’s ID Card. Providers will call the membership phone number listed on the ID card to verify benefits.

	Indemnity Dental Plan Your Cost at In-Network Providers
NETWORK	Platinum Co-Insurance
DEDUCTIBLE (Calendar Year)	
Individual	\$50
Family	\$150
SERVICES	
Preventive Routine exams, cleanings (2 per year), fluoride, x-rays	0% (Deductible Waived)
Basic Fillings, extractions, oral surgery, endodontics, periodontics	20%
Major Crown, bridges, dentures	50%
ORTHODONTIA	
All Members	None
WAITING PERIODS	
	None
MAXIMUMS (Calendar Year)	
Preventive, Basic, Major	\$1,500 per member
Orthodontia:	None
Out of Network Reimbursement	90th

Indemnity Dental Plan

An Indemnity plan allows the member to see in and out of network providers. This would be a good plan to choose if you do not want to change your current dentist even if they are not in the carrier network. In-network benefits are paid on a percentage basis and an annual deductible will apply. Once you have reached the stated annual maximum, the dental carrier will not pay out any more for claims for that member.

Registration on carrier website:

We highly recommend that you register as a member with all carriers to gain access to additional benefit information as well as perks for being a member. You will need to have your ID card handy when registering.

1. Visit www.dentalselect.com
2. Select "Members"
3. Select "Member Portal Log-In"
4. Select "Register"

FILING A CLAIM

If you are using an in-network dentist, they will file all claims on your behalf. Out of network providers may require you to submit claims for processing. See your HR Department for claim forms.

FINDING A PROVIDER

Please visit the Dental Select website at www.dentalselect.com to find a list of providers in your area. You will need to use the network names listed on the Benefits Directory page for the corresponding plan while performing the search to create the most accurate list.

VOLUNTARY VISION INSURANCE



Dental Select will serve as the vision insurance provider for this plan year. This benefit is a voluntary benefit and paid 100% by the employee. You are responsible for all employee and dependent cost through payroll deductions. This plan will allow you to improve your health through a comprehensive eye exam, while saving you money on your eye care purchases.

	In-Network
Network	Access Vision
Exam	\$10 Copay
Contact Lens Options: <i>Standard fit and follow-up</i>	Covered Up to \$55
Frames	\$130 allowance; 20% off balance
Standard Plastic Lenses: <i>Single Vision</i> <i>Bifocal</i> <i>Trifocal</i>	\$25 Copay \$25 Copay \$25 Copay
Contact Lenses <i>Disposable</i>	*Contacts are in-lieu of glasses* \$150 Allowance
Laser Vision Correction <i>LASIK or PRK</i>	15% off Retail
Frequency <i>Exam</i> <i>Frames</i> <i>Lenses or Contacts</i>	Once every 12 months Once every 12 months Once every 12 months

FINDING A PROVIDER

Please visit the Dental Select website at www.dentalselect.com to find a list of providers in your area. You will need to use the network name listed on the Benefits Directory page for the corresponding plan while performing the search to create the most accurate list.

LIFE & AD&D INSURANCE



Neos Consulting Group will provide all full-time employees with a \$50,000 Basic Life and Accidental Death & Dismemberment for the employee at no cost.

EMPLOYER PAID TERM LIFE & AD&D	
Term Life Insurance/ Accidental Death & Dismemberment (AD&D) Full-Time Employees	\$50,000
Guarantee Issue Full-Time Employees	\$50,000
Age Reduction Schedule	35% at age 60; 60% at age 70; 75% at age 75

LOW COST GENERICS PROGRAMS

Many pharmacies have established their own discounted generics programs to help individuals save money on generic prescriptions. These programs are not associated with your medical insurance benefits so you would **NOT** show the pharmacy your insurance card when using these programs. Due to the fact that a claim is not being submitted to your medical carrier, you do not get deductible credit for any purchased prescriptions but the lower cost of these drugs is often less than the listed copays on the medical plans.

Below is a brief summary of some of the programs for the major pharmacy providers. Be sure to check with your pharmacy to see what programs they offer if they are not listed below.

 <p>www.heb.com/pharmacy \$4, \$8 or \$12 for 30-day Supply \$10, \$20 or \$30 for 90-day Supply</p>	 <p>www.walmart.com/pharmacy \$4 for 30-day Supply \$10 for 90-day Supply</p>
 <p>www.costco.com Member Prescription Program Offers a discount on all branded and generic prescription medications</p>	 <p>www.target.com/pharmacy/generics \$4 for 30-day Supply \$10 for 90-day Supply</p>
 <p>www.cvs.com/healthsavingspass \$11.99 for 90-day Supply 10% off at MinuteClinic</p>	 <p>AT THE CORNER OF HAPPY & HEALTHY™ www.walgreens.com/pharmacy 30-day Supply: \$5(tier 1) \$10(tier 2) \$15 (tier 3) 90-day Supply: \$10 (tier 1)\$20 (tier 2) \$30 (tier 3) \$20 Individual/\$35 Family Membership Fee</p>

NOTES:

MANDATORY NOTICES

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

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying

events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone

numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.



COBRA

TEXAS

Comparison of Federal and Texas Continuation Laws

	FEDERAL (COBRA)	TEXAS
Covered Employers and Plan Coverage	<p>Group health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments.</p> <p>Coverage must be 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).</p>	<p>An insurer that provides group hospital, surgical or major medical expense coverage must provide continuation coverage if eligibility criteria is met. Dental, vision and prescription plans are not required to be included.</p> <p>Does not apply to policies that provide only benefits for specified disease and accident expenses.</p>
Qualified Beneficiaries (Employee / Dependents)	<p>An employee, spouse or dependent child covered by a group health plan on the day before a qualifying event.</p> <p>In certain cases, a retired employee, the retired employee's spouse and the retired employee's dependent children may be qualified beneficiaries.</p> <p>In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.</p> <p>Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.</p>	<p>Employees and dependents with at least three consecutive months of coverage prior to termination.</p> <p>A family member or dependent who has been a member of the group for at least one year is eligible for continued coverage for certain additional qualified events.</p>
Continuation Period	<p>18 months - COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.</p> <p>29 months - Disability can extend the 18-month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. If certain requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.</p>	<p>9 months (or 6 months, where COBRA eligible) – Eligible employees and dependents must be offered up to a 9 month continuation period. Where eligible for COBRA, eligible employees and dependents must be offered 6 additional months following COBRA.</p>

	<p>36 months - Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.</p> <p>36 months - Under COBRA, participants, covered spouses and dependent children may continue their plan coverage when they would otherwise lose coverage due to divorce (or legal separation) for a maximum of 36 months.</p>	
<p>Qualifying Events</p>	<p>Qualifying Events for Employees:</p> <ul style="list-style-type: none"> • Voluntary or involuntary termination of employment for reasons other than gross misconduct (18 months) • Reduction in the number of hours of employment (18 months) <p>Qualifying Events for Spouses:</p> <ul style="list-style-type: none"> • Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct (18 months) • Reduction in the hours worked by the covered employee (18 months) • Covered employee's becoming entitled to Medicare (36 months) • Divorce or legal separation of the covered employee (36 months) • Death of the covered employee (36 months) <p>Qualifying Events for Dependent Children:</p> <ul style="list-style-type: none"> • Loss of dependent child status under the plan rules (36 months) • Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct (18 months) • Reduction in the hours worked by the covered employee (18 months) • Covered employee's becoming entitled to Medicare (36 months) 	<p>Qualifying Events for Employees:</p> <ul style="list-style-type: none"> • Coverage ends for any reason other than involuntary termination of employment for cause. <p>Qualifying Events for Spouses:</p> <ul style="list-style-type: none"> • Coverage ends for any reason other than involuntary termination of employment for cause. <p>Qualifying Events for Dependent Children:</p> <ul style="list-style-type: none"> • Coverage ends for any reason other than involuntary termination of employment for cause. <p>If a family member or dependent has been a member of the group insurance for a period of at least one year (or if an infant under one year of age), he or she is eligible for continuation coverage if the policy is terminated because of:</p> <ul style="list-style-type: none"> • Severance of family relationship, such as divorce or legal separation of group member. • Retirement or death of group member.

	<ul style="list-style-type: none"> • Divorce or legal separation of the covered employee (36 months) • Death of the covered employee (36 months) 	
Eligibility	<p>To be eligible for COBRA coverage, must have been enrolled in employer's health plan when employed and health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.</p>	<p>Eligibility is dependent upon whether the covered individual had been covered for at least three consecutive months prior to the termination of coverage.</p> <p>Additional continuation coverage is available to a family member or dependent (or an infant under one year of age) who has been a member of the group insurance for at least one year.</p>
Notice Requirements	<p>Health plan administrators must provide an initial general notice when group health coverage begins.</p> <p>When a qualifying event occurs, health plan administrators must provide an election notice regarding rights to COBRA continuation benefits to each qualifying beneficiary who loses plan coverage in connection with the qualifying event.</p> <p>Employers must notify their plan administrators within 30 days after an employee's termination or after a reduction in hours that causes an employee to lose health benefits.</p> <p>The plan administrator must provide notice to individual employees of their right to elect COBRA coverage (election notice) within 14 days after the administrator has received notice from the employer.</p> <p>Employee must respond to this notice and elect COBRA coverage by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later. Otherwise, employee will lose all rights to COBRA benefits.</p> <p>Spouses and dependent children covered under such health plan have independent rights to elect COBRA coverage upon employee's termination or reduction in hours.</p>	<p>The individual must apply for continuation coverage within 60 days of the later of:</p> <ul style="list-style-type: none"> • Termination of group coverage; or • The date on which the notice of continuation rights was received. <p>Employers must provide a written notice to each covered individual that is affected by the termination of conversion or continuation privileges.</p> <p>Employers are required to notify individuals on continuation coverage that they may be entitled to coverage under the Texas Health Insurance Risk Pool. This notice must be sent at least 30 days prior to the end of the continuation period applicable to the individual.</p> <p>A dependent must apply for continuation coverage within 60 days after the date of the severance of the family relationship or the retirement or death of the employee.</p>
Termination of Coverage	<p>Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the</p>	<p>Coverage must be allowed to continue until the earliest of the following:</p>

	<p>maximum period. It may end earlier if:</p> <ul style="list-style-type: none"> • Premiums are not paid on a timely basis. • The employer ceases to maintain any group health plan. • After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election. • After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election. 	<ul style="list-style-type: none"> • The date coverage would end due to the individual's failure to pay required premiums; • The group policy terminates; • The individual becomes eligible for Medicare or similar benefits under another plan; or • The individual becomes eligible for coverage under a state or federal law other than COBRA. <p>The coverage of a family member or dependent who obtains continuation coverage because of the severance of the family relationship, retirement or death of the employee must be allowed to continue until the earliest of the following:</p> <ul style="list-style-type: none"> • The dependent fails to make payment within required timeframe; • The dependent becomes eligible for similar benefits under another plan; or • The third anniversary of the severance of the family relationship or the retirement or death of the employee.
<p>Conversion Rights</p>	<p>Some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.</p>	<p>The State of Texas mandates that individuals "shall have the option to convert or continue insurance" after the expiration of COBRA coverage.</p> <p>Insurers may offer a conversion policy without evidence of insurability if a written application and a first premium payment are made no later than 31 days after the date coverage terminates.</p>

Other		<p>Through the Texas Health Insurance Risk Pool (Health Pool), Texas offers insurance to Texans who cannot find coverage due to a preexisting condition, as well as to certain residents who have recently lost coverage.</p> <p>Note that special rules apply to continuation coverage under Texas laws when loss of coverage is due to a labor dispute.</p>
Applicable Statutes	IRC § 4980B, ERISA §601 <i>et seq.</i>	Tex. Ins. Code Title 8; Tex. Admin. Code Title 28
Government Agency Contact	<p>Departments of Labor and Treasury (private sector plans) and Department of Health and Human Services (public sector plans). More information on COBRA coverage is available from the Department of Labor at: www.dol.gov/dol/topic/health-plans/cobra.htm.</p>	Texas Department of Insurance

This Chart is provided to you for general informational purposes only. It broadly summarizes state and federal statutes, but does not include references to other legal resources (e.g., supporting regulations, or formal or informal opinions of state offices of commissioners of insurance) unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of the topics discussed herein to your employee benefits plans.

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(6/09; BK 11/12)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act of 1996. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother's and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Women's Health and Cancer Rights Act (WHCRA)

Reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance, is covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all states of the mastectomy, including lymphedemas.

Genetic Information Nondiscrimination Act (GINA)

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.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights as they pertain to your health insurance benefits. You will receive a separate “Notice of Privacy Provisions” from the Insurer which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer involved with the PHI in question. The Insurer will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Employer or Plan Sponsor with respect to such information. The Employer or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan’s use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed

positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan Sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Insurer within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Insurer may provide this information by phone.

NOTICE OF PATIENT PROTECTIONS

Your employer's plan 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 your company's HR department.

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

You do not need prior authorization from your employer's 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 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 your company's HR department.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage.

01/12

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Important Notice from About Your Prescription Drug Coverage and Medicare

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

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

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

CMS Form 10182-CC

Updated April 1, 2011

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Medicare eligible individuals can keep this group plan coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

You should also know that if you drop or lose your current coverage with and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact your HR Department for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

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, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/Premiu	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

mAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/ofc/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, 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)

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

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

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor Wage and Hour Division



WHD Publication 1420 · Revised February 2013



YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

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

then an employer may not deny you:

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

because of this status.

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

HEALTH INSURANCE PROTECTION

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

ENFORCEMENT

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

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



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

U.S. Department of Justice Office of Special Counsel

1-800-336-4590

Publication Date—October 2008



Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for insured health plans. Mandates can affect various parts of health insurance plans as follows:

- **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures.
- **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form of nondiscrimination mandates that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For instance, effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act (ACA) requires non-grandfathered plans in the small group and individual markets to provide coverage for items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains a chart outlining Texas' benefit, provider and person mandates for group health insurance plans. Please keep in mind that the following chart does not address federal benefit mandates, such as the ACA's mandates.

Benefit Mandate	Description
Acquired Brain Injury	Coverage for the treatment of an acquired brain injury, including cognitive rehabilitation therapy, neurofeedback therapy, post-acute transition services and community reintegration services. The same payment limitations, deductibles, copayments and coinsurance factors as apply to other similar coverage under the plan must apply to brain injury coverage.
Alzheimer's Disease	If a health benefit plan provides coverage for Alzheimer's disease and requires demonstrable proof of organic disease or other proof before the issuer authorizes payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a licensed physician, including a history, physical, neurological and psychological or psychiatric evaluations and laboratory studies.
Amino Acid-Based Elemental Formulas	Coverage for medically necessary amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of: <ul style="list-style-type: none"> • Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

Health insurance mandates differ from state to state and often contain detailed criteria. This chart provides a general overview of health insurance mandates and is provided to you for general informational purposes only. It summarizes mandates contained in state statutes, but does not include references to other legal resources (such as supporting regulations, or formal or informal opinions of state departments of insurance), unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of health insurance mandates to your employee benefits plans.
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	<ul style="list-style-type: none"> • Severe food protein-induced enterocolitis syndrome; • Eosinophilic disorders, as evidenced by the results of a biopsy; and • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract. <p>Must include coverage of any medically necessary services associated with the administration of the formula. Coverage must be no less favorable than the plan's coverage for prescription drugs and other medications and related services, and must be provided to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.</p>
Autism Spectrum Disorder	<p>Coverage to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis through age nine for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.</p> <p>Covered services may include:</p> <ul style="list-style-type: none"> • Evaluation and assessment services; • Applied behavior analysis; • Behavior training and behavior management; • Speech therapy; • Occupational therapy; • Physical therapy; or • Medications or nutritional supplements used to address symptoms of autism spectrum disorder. <p>May be subject to annual deductibles, copayments and coinsurance that are consistent with those required for other coverage under the health benefit plan.</p> <p>"Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's syndrome or Pervasive Developmental Disorder--Not Otherwise Specified.</p>
Breast Cancer Surgery – Inpatient Care	<p>A health benefit plan that provides coverage for the treatment of breast cancer must provide coverage for inpatient care for a minimum of:</p> <ul style="list-style-type: none"> • 48 hours following a mastectomy; and • 24 hours following a lymph node dissection for the treatment of breast cancer. <p>A health benefit plan is not required to cover this length of inpatient care if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.</p> <p>This mandate does not apply to small health benefit plans (employers with 50 or fewer employees).</p>
Cancer Clinical Trials – Routine Patient Care	<p>Coverage for routine patient care costs in connection with a phase I, phase II, phase III or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life-threatening</p>

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	<p>disease or condition and receives appropriate approval.</p> <p>May be subject to a deductible, coinsurance or copayment requirement comparable to the plan's other cost-sharing requirements.</p>
Cancer Treatments – Orally-Administered Anti-Cancer Drugs	<p>A health benefit plan that provides coverage for cancer treatment must provide coverage for a prescribed, orally-administered anti-cancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than plan's coverage for intravenously administered or injected cancer medications.</p> <p>The cost to the covered individual of the orally-administered drug may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit.</p>
Cardiovascular Disease – Early Detection Tests	<p>A health benefit plan that provides coverage for screening medical procedures must provide coverage up to \$200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years:</p> <ul style="list-style-type: none"> • Computed tomography (CT) scanning measuring coronary artery calcification; or • Ultrasonography measuring carotid intima-media thickness and plaque. <p>This coverage must be provided to males between the ages of 46 and 75 and females between the ages of 56 and 75 who are diabetic or at risk of developing coronary heart disease.</p>
Cervical Cancer and HPV Screening	<p>A health benefit plan that provides coverage for diagnostic medical procedures must cover an annual examination for the early detection of cervical cancer for women age 18 or older.</p>
Chemical Dependency Treatment	<p>Coverage for the necessary care and treatment of chemical dependency. "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.</p> <p>Coverage is limited to a lifetime maximum of three separate treatment series for each covered individual. Necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.</p> <p>Coverage may not be less favorable than the plan's coverage provided for physical illness generally, except to the extent that different dollar or durational limits are sufficient to provide appropriate care and treatment under guidelines issued by the Texas Department of Insurance.</p>
Childhood Immunizations	<p>A health benefit plan that provides family coverage must provide immunization coverage for each covered child from birth through age 6 against:</p> <ul style="list-style-type: none"> • Diphtheria; • Haemophilus influenzae type b; • Hepatitis B; • Measles; • Mumps; • Pertussis;

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	<ul style="list-style-type: none"> • Polio; • Rubella; • Tetanus; • Varicella; and • Any other immunization that is required for the child by law. <p>May not be subject to a deductible, copayment or coinsurance requirement.</p> <p>Mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
Colon Cancer Screenings	<p>A health benefit plan that provides coverage for screening medical procedures must provide coverage for colon cancer screenings for enrolled individuals who are age 50 or older and at normal risk for developing colon cancer. This coverage must include a:</p> <ul style="list-style-type: none"> • Fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or • A colonoscopy performed every 10 years. <p>This mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
Contraceptive Coverage	<p>A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:</p> <ul style="list-style-type: none"> • A prescription contraceptive drug or device approved by the U.S. Food and Drug Administration (FDA); or • An outpatient contraceptive service. <p>Mandate does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy. Cannot impose a deductible, copayment, coinsurance or other cost-sharing provision to this coverage that is more than the amount of the required cost-sharing for other prescription drugs or devices or outpatient services under the plan.</p> <p>Exception applies for health benefit plans associated with religious organizations, unless the prescription contraceptive coverage is necessary to preserve the life or health of the enrollee.</p>
Craniofacial Abnormalities - Children	<p>A health benefit plan that provides family coverage must define “reconstructive surgery for craniofacial abnormalities” to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease for a child who is younger than 18 years of age.</p> <p>Mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
Development Delays – Children	<p>Must offer coverage for rehabilitative and habilitative therapies for a child that includes:</p> <ul style="list-style-type: none"> • Occupational therapy evaluations and services; • Physical therapy evaluations and services;

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	<ul style="list-style-type: none"> • Speech therapy evaluations and services; and • Dietary or nutritional evaluations. <p>The rehabilitative and habilitative therapies must be covered in the amount, duration, scope and service setting established in the child's individualized family service plan. The therapies may not be applied to a plan's annual or lifetime maximum benefit.</p> <p>Mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
Diabetes	<p>Coverage for diabetes equipment, supplies and self-management training. Cannot be subject to a deductible, coinsurance or copayment requirement that exceeds the cost-sharing applicable to similar coverage under the plan.</p> <p>Covered equipment and supplies include such items as:</p> <ul style="list-style-type: none"> • Blood glucose monitors, including those designed to be used by or adapted for the legally blind; • Test strips specified for use with a corresponding glucose monitor; • Lancets and lancet devices; • Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; • Insulin and insulin analog preparations; • Injection aids, including devices used to assist with insulin injection and needleless systems; • Insulin syringes; • Biohazard disposal containers; and • Insulin pumps, both external and implantable, and associated appurtenances. <p>Diabetes self-management training must be covered when:</p> <ul style="list-style-type: none"> • Diabetes is initially diagnosed; • A significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime; or • Periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes. <p>This mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
Fertility Treatment – In Vitro Fertilization	<p>An issuer of a group health benefit plan that provides pregnancy-related benefits must offer coverage for in vitro fertilization procedures. Benefits for in vitro fertilization must be provided to the same extent as plan benefits for other pregnancy-related procedures.</p> <p>Coverage must only be provided if:</p> <ul style="list-style-type: none"> • The in-vitro patient is covered by the health plan; • The fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse; • The patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is

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	<p>associated with:</p> <ul style="list-style-type: none"> ○ Endometriosis; ○ Exposure in utero to diethylstilbestrol (DES); ○ Blockage of or surgical removal of one or both fallopian tubes; or ○ Oligospermia. <ul style="list-style-type: none"> • The patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which plan coverage is available; and • The in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards adopted by the American Society for Reproductive Medicine. <p>Required coverage offering does not apply to issuers connected with certain religious denominations.</p>
Hearing Tests for Children	<p>A health benefit plan that provides family coverage must provide coverage for:</p> <ul style="list-style-type: none"> • A screening test for hearing loss from birth to 30 days of age; and • Necessary diagnostic follow-up care related to the screening test from birth to 24 months of age. <p>May not be subject to a deductible, copayment or coinsurance requirement.</p> <p>Mandate does not apply to small employer health benefit plans (50 or fewer employees).</p>
HIV, AIDS or HIV-Related Illnesses	<p>Coverage for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or an HIV-related illness.</p>
Home Health Care	<p>Must offer coverage for home health services provided by a home health agency. A group health benefit plan may include:</p> <ul style="list-style-type: none"> • A limit on the number of covered visits for home health services for which benefits are payable, provided the limit cannot be less than 60 visits per year; • An exclusion for: <ul style="list-style-type: none"> ○ Custodial care; ○ Services provided by an individual who resides in the covered individual's home or is a member of the covered individual's family; or ○ Services provided to a covered individual who is eligible for Medicare coverage. <p>The annual deductible and coinsurance provisions for home health services cannot be less favorable than those that apply to the plan's coverage for hospital services coverage.</p>
Mammograms	<p>Coverage for an annual screening by low-dose mammography for the presence of occult breast cancer for a female who is 35 years of age or</p>

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	<p>older.</p> <p>Coverage cannot be less favorable than coverage for other radiological examinations under the plan, and it must be subject to the same dollar limits, deductibles and coinsurance factors.</p>
Mastectomy – Reconstructive Surgery	<p>A health benefit plan that provides coverage for a mastectomy must provide coverage for:</p> <ul style="list-style-type: none"> • Reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and • Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy <p>May be subject to annual deductibles, copayments and coinsurance that are consistent with those required for other coverage under the health benefit plan. Cannot be subject to dollar limits other than the lifetime maximum benefits under the plan.</p>
Maternity – Inpatient Stay and Post-Delivery Care	<p>A health benefit plan that provides maternity benefits, including benefits for childbirth, must provide coverage to a woman and her newborn child for inpatient care in a health care facility for not less than:</p> <ul style="list-style-type: none"> • 48 hours after an uncomplicated vaginal delivery; and • 96 hours after an uncomplicated delivery by cesarean section. <p>If a decision is made to discharge a woman or the newborn child from inpatient care early, a health benefit plan must provide coverage for timely post-delivery care.</p>
Medically Necessary Foods and Formulas	<p>Coverage for formulas necessary to treat phenylketonuria or a heritable disease. Coverage must be provided to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.</p>
Mental Health – Alternative Treatment Benefits	<p>A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital.</p> <p>This coverage must be subject to the same benefit maximums, durational limitations, deductibles and coinsurance factors that apply to inpatient psychiatric treatment under the plan.</p> <p>For purposes of determining plan benefits and maximums, each two days of treatment in a residential treatment center or in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.</p>
Mental Health – Psychiatric Day Treatment Facility	<p>Must offer coverage for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility. The psychiatric day treatment facility coverage may not be less favorable than the hospital coverage and must be subject to the same</p>

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	<p>durational limits, deductibles, and coinsurance factors.</p>
<p>Mental Health – Serious Mental Illness</p>	<p>Coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:</p> <ul style="list-style-type: none"> • 45 days of inpatient treatment; and • 60 visits for outpatient treatment, including group and individual outpatient treatment. <p>Cannot include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment. Must include the same amount limitations, deductibles, copayments and coinsurance factors for serious mental illness as the plan includes for physical illness.</p> <p>Coverage is not required for the treatment of addiction to a controlled substance or marihuana that is used in violation of law or mental illness that results from the use of a controlled substance or marihuana in violation of law.</p> <p>An issuer of a group health benefit plan to a small employer (50 employees or less) must offer the coverage for serious mental illness, but the employer is free to reject the coverage.</p> <p>“Serious mental illness” means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):</p> <ul style="list-style-type: none"> • Bipolar disorders (hypomanic, manic, depressive, and mixed); • Depression in childhood and adolescence; • Major depressive disorders (single episode or recurrent); • Obsessive-compulsive disorders; • Paranoid and other psychotic disorders; • Schizo-affective disorders (bipolar or depressive); and • Schizophrenia. <p><i>The federal Mental Health Parity and Addiction Equity Act (MHPAEA) creates additional parity requirements for employers with more than 50 employees that offer mental health or substance use disorder benefits in their group health plans. Depending on a plan’s design, the MHPAEA may require stricter parity requirements than state law mandates. Also, beginning in 2014, the ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services and comply with the federal parity law.</i></p>
<p>Osteoporosis</p>	<p>Coverage to qualified enrollees for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis.</p> <p>“Qualified enrollee” means:</p> <ul style="list-style-type: none"> • A postmenopausal woman who is not receiving estrogen replacement therapy; • An individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or • An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an

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	approved osteoporosis drug therapy.
Prescription Drugs	<p>A health benefit plan that covers drugs must cover any drug prescribed to treat an enrollee for a chronic, disabling or life-threatening illness covered under the plan if the drug:</p> <ul style="list-style-type: none"> • Has been approved by the FDA for at least one indication; and • Is recognized by certain medical compendium or literature for treatment of the indication for which the drug is prescribed. <p>Coverage must include medically necessary services associated with the administration of the drug. May not deny coverage based on a “medical necessity” requirement unless the denial reason is unrelated to the legal status of the drug use.</p> <p>Mandate does not require a health benefit plan to cover:</p> <ul style="list-style-type: none"> • Experimental drugs that are not otherwise approved for an indication by the FDA; • Any disease or condition that is excluded from coverage under the plan; or • A drug that the FDA has determined to be contraindicated for treatment of the current indication. <p>Mandate does not apply to small employer (50 or less employees) health benefit plans.</p>
Prostate Cancer Screenings	<p>A health benefit plan that provides coverage for diagnostic medical procedures must provide coverage for expenses for an annual examination for the detection of prostate cancer.</p> <p>This coverage must include a physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male who is at least:</p> <ul style="list-style-type: none"> • 50 years of age and is asymptomatic; or • 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor. <p>Mandate does not apply to small employer (50 or fewer employees) health benefit plans.</p>
Prosthetics and Orthotic Devices	<p>Coverage for prosthetic devices, orthotic devices and professional services related to the fitting and use of those devices that equals the coverage provided under the Medicare program.</p> <p>May be subject to annual deductibles, copayments and coinsurance that are consistent with those required for other coverage under the health benefit plan. Cannot be subject to annual dollar limits.</p>
Speech or Hearing – Loss or Impairment	<p>Issuers must offer coverage for the necessary care and treatment of loss or impairment of speech or hearing. This coverage cannot be less favorable than coverage for physical illness generally under the plan. It must be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as coverage for physical illness generally under the plan.</p>
Telemedicine/Telehealth	<p>May not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided</p>

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	<p>through a face-to-face consultation.</p> <p>The amount of any deductible, copayment or coinsurance may not exceed the amount of the cost-sharing required for a comparable medical service provided through a face-to-face consultation.</p> <p>Mandate does not apply to small employer (50 or fewer employees) health benefit plans.</p>
Temporomandibular Joint (TMJ)	<p>A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint (TMJ) if the treatment is medically necessary as a result of:</p> <ul style="list-style-type: none"> • An accident or trauma; • A congenital defect; • A developmental defect; or • A pathology. <p>May be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. Mandate does not require coverage for dental services if dental services are not otherwise scheduled or provided as part of the plan's coverage.</p> <p>Mandate does not apply to small employer (50 or fewer employees) health benefit plans.</p>

Provider Mandate	Description
Acupuncturist	An individual licensed to practice acupuncture by the Texas State Board of Medical Examiners. Nondiscrimination mandate. A nondiscrimination mandate requires coverage if the health plan reimburses services within the scope of the health care professional's practice.
Advanced Practice Nurse	An individual licensed by the Texas Board of Nursing as a registered nurse and as an advanced practice nurse. Nondiscrimination mandate.
Audiologist	An individual licensed to practice audiology by the Texas State Board of Examiners for Speech-Language Pathology and Audiology. Nondiscrimination mandate.
Chemical Dependency Counselor	An individual licensed by the Texas Commission on Alcohol and Drug Abuse. Nondiscrimination mandate.
Chiropractor	An individual licensed by the Texas Board of Chiropractic Examiners. Nondiscrimination mandate.
Clinical Social Worker	An individual licensed by the Texas State Board of Social Worker Examiners as a licensed clinical social worker. Nondiscrimination mandate.
Dentist	An individual licensed to practice dentistry by the Texas State Board of Dental Examiners. Nondiscrimination mandate.

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Dietician	An individual licensed by the Texas State Board of Examiners of Dieticians. Nondiscrimination mandate.
Hearing Instrument Fitter and Dispenser	An individual licensed by the Texas State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments. Nondiscrimination mandate.
Marriage and Family Therapist	An individual licensed by the Texas State Board of Examiners of Marriage and Family Therapists. Nondiscrimination mandate.
Nurse First Assistant	An insured may select a nurse first assistant to provide the services scheduled in the health insurance policy that are within the scope of the nurse's licensed and requested by the physician who the nurse is assisting. Nondiscrimination mandate.
Occupational Therapist	An individual licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners. Nondiscrimination mandate.
Optometrist	An individual licensed to practice optometry by the Texas Optometry Board. Nondiscrimination mandate.
Physical Therapist	An individual licensed as a physical therapist by the Texas Board of Physical Therapy. Nondiscrimination mandate.
Physician Assistant	An individual licensed by the Texas State Board of Physician Assistant Examiners. Nondiscrimination mandate.
Podiatrist	An individual licensed to practice podiatry by the Texas State Board of Podiatric Medical Examiners. Nondiscrimination mandate.
Professional Counselor	An individual licensed by the Texas State Board of Examiners of Professional Counselors. Nondiscrimination mandate.
Psychological Associate	An individual licensed as a psychological associate by the Texas State Board of Examiners of Psychologists who practices solely under the supervision of a licensed psychologist. Nondiscrimination mandate.
Psychologist	An individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists. Nondiscrimination mandate.
Speech-Language Pathologist	An individual licensed to practice speech-language pathology by the Texas State Board of Examiners for Speech-Language Pathology and Audiology. Nondiscrimination mandate.
Surgical Assistant	An individual licensed as a surgical assistant by the Texas State Board of Medical Examiners. Nondiscrimination mandate.

Person Mandate	Description
Adopted Children	A group policy that provides coverage for the immediate family or a child of an insured may not exclude from coverage or limit coverage of a child solely because the child is adopted.
Child of Spouse	A group policy that provides coverage for a child of an insured may not

Health Insurance Mandates

	exclude a child from coverage because the child is the natural or adopted child of the insured's spouse.
Continuation Coverage	<p>Must offer continuation coverage to employees and dependents when:</p> <ul style="list-style-type: none"> • Group coverage is terminated for any reason (other than involuntary termination for cause); and • The individual has been continuously insured under the group policy for at least three consecutive months before termination. <p>The maximum continuation period is nine months, or, if the individual is eligible for federal COBRA coverage, six additional months following any period of COBRA coverage.</p> <p>If a family member's or dependent's coverage would end because of severance of the family relationship or the insured's retirement or death, and the family member or dependent has been a member of the group for a least one year (or is an infant under one year of age), continuation coverage may be elected for a maximum period of three years.</p>
Conversion Coverage	An insurer may offer a conversion policy to each employee, member or dependent who is covered under a group accident and health insurance policy that is terminating.
Dependent - Adult Child Coverage	A group policy that provides family coverage must cover an unmarried child younger than 25 years of age.
Dependent – Disability Extension	<p>A group policy that has an age limit for dependent coverage must provide that a child's attainment of that age does not terminate coverage while the child is:</p> <ul style="list-style-type: none"> • Incapable of self-sustaining employment because of mental retardation or physical disability; and • Chiefly dependent on the insured for support and maintenance.
Grandchildren	<p>A group policy that provides family coverage must provide coverage for any grandchild of the insured if the grandchild is:</p> <ul style="list-style-type: none"> • Unmarried; • Younger than age 25; and • A dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made. <p>Coverage for a grandchild may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes.</p>
Newborn Children	<p>A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not exclude or limit:</p> <ul style="list-style-type: none"> • Initial coverage of a newborn child for a period of time; or • Coverage for congenital defects of a newborn child.

**While many of the mandates described in the above chart are applicable to health maintenance organizations (HMOs) and preferred provider plans (PPPs), HMOs and PPPs may be subject to additional requirements under Texas statutes and regulations that are not specifically addressed in the above chart. In addition, the chart focuses on mandates*

Health Insurance Mandates

applicable to health insurance plans sponsored by private employers, and does not address mandates specifically applicable to the health benefits provided by government employers.

Under Texas law, issuers may offer consumer choice plans that are not required to comply with all of the health insurance mandates described above. Consumer choice plans are required to provide members with a disclosure statement and a list of the benefits that are not covered.

ADDITIONAL RESOURCES

Texas statutes: www.legis.state.tx.us

Texas Department of Insurance: www.tdi.texas.gov

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

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

➤ *See page 2 for more information on these rights and how to exercise them*

Your Choices

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

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

➤ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

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

➤ *See pages 3 and 4 for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

continued on next page

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

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

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

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

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

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

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

