**Benefits Notices Templates**

**for Small Business**

# Employee Benefits Series

**FOR EMPLOYERS WITH 1-19 EMPLOYEES**





**Benefits Notices Templates for Small Business**

**For Employers with 1-19 Employees**

The following is a list of key model benefits notices that may apply to group health plans under federal law. These model notices are for **general reference purposes** only—your company may be exempt from certain requirements and/or subject to additional obligations under your state's laws.As changes in the law, rules, regulations, and interpretations can occur, please contact a knowledgeable attorney to review any forms or documentation you intend to distribute to employees.

## Table of Contents

* [Summary of Material Modifications](#SMMSMB)\* (SMM) and [Summary of Material Reduction in Covered Services or Benefits](#SMMSMB)\*
* [Health Insurance Exchange Notice](#HIEN)\*
* [Summary of Benefits and Coverage (SBC) & Uniform Glossary](#SBC)\*
* [Disclosure of Grandfather Status](#Grandfather)\*
* [Notice of Patient Protections](#NPP)\*
* [Notice of Special Enrollment Rights](#NSER)\*
* [Wellness Program Disclosure](#WPD)\*
* [Notice of Privacy Practices](#NPPractices)\*
* [Women's Health & Cancer Rights Act (WHCRA) Notices](#WHCRA)\*
* [Mental Health Parity & Addiction Equity Act (MHPAEA) Disclosure](#MHPAEA)\*
* [Employer Children's Health Insurance Program (CHIP) Notice](#CHIP)
* [Michelle's Law Notice](#Michelle)\*
* [Newborns' and Mothers' Health Protection Act Notice](#Newborns)
* [Medicare Part D Creditable Coverage Disclosure Notice](#MedicareCred)\* or [Medicare Part D Non-Creditable Coverage Disclosure Notice](#MedicareNonCred)\*
* [Genetic Information Nondiscrimination Act (GINA) Disclosures](#GINA)
* [ADA Notice Regarding Wellness Program](#ADAWellness)\*

\****Important Note*: Customization will be required before distribution of the model notices marked above**. While some customization will be minimal (e.g., inserting applicable contact information), **employers and plan administrators are advised to tailor each notice to meet their particular company's needs prior to distribution**.

**Summary of Required Benefits Notices for Employers with 1-19 Employees**

|  |  |  |
| --- | --- | --- |
| Employee Retirement Income Security Act (ERISA) Notices | | |
| **Notice** | **Provide To** | **When Due** |
| [Summary of Material Modifications (SMM)](#SMMSMB)  and  [Summary of Material Reduction in Covered Services or Benefits](#SMMSMB) | Group health plan participants | No later than 210 days after the end of the plan year in which the change is adopted, for material changes to the plan that do not result in a material reduction in covered services or benefits  Within 60 days of adoption of a material reduction in covered services or benefits (alternatively, notice may be provided with plan information that is furnished at regular intervals of not more than 90 days, if [certain conditions](http://www.ecfr.gov/cgi-bin/text-idx?SID=9c0d3f8b2a2062bc995e86fab8ea2db3&node=29:9.1.3.3.4.6.10.3&rgn=div8) are met) |
| Health Care Reform Notices | | |
| **Notice** | **Provide To** | **When Due** |
| [Health Insurance Exchange Notice](#HIEN) | All new employees | Within 14 days of an employee's start date |
| [Summary of Benefits and Coverage (SBC) & Uniform Glossary](#SBC) | Group health plan participants & beneficiaries | At [specified times](http://www.dol.gov/ebsa/faqs/faq-aca8.html) during the enrollment process and upon request |
| [Disclosure of Grandfather Status](#Grandfather) | Group health plan participants & beneficiaries | In any plan materials for a grandfathered group health plan provided to a participant or beneficiary describing the benefits provided under the plan |
| [Notice of Patient Protections](#NPP) | Group health plan participants | Whenever a participant in a non-grandfathered group health plan that requires or provides for the designation of a participating primary care provider is furnished an Summary Plan Description (SPD) or other similar description of benefits under the plan |
| Health Insurance Portability and Accountability Act (HIPAA) Notices | | |
| **Notice** | **Provide To** | **When Due** |
| [Notice of Special Enrollment Rights](#NSER) | Employees eligible to enroll in the employer's group health plan | At or before the time an employee is initially offered the opportunity to enroll in the plan |

|  |  |  |
| --- | --- | --- |
| Health Insurance Portability and Accountability Act (HIPAA) Notices (continued) | | |
| **Notice** | **Provide To** | **When Due** |
| [Wellness Program Disclosure](#WPD) | Group health plan participants & beneficiaries eligible to participate in a [health-contingent wellness program](http://www.dol.gov/ebsa/pdf/caghipaaandaca.pdf) | In all plan materials that describe the terms of the health-contingent wellness program (if the plan materials merely mention that a program is available, without describing its terms, disclosure is not required) and in any disclosure that an individual did not satisfy an initial outcome-based standard |
| [Notice of Privacy Practices](#NPPractices)  **Note**: Fully insured group health plans that do not create or receive protected health information (PHI)— other than summary health and enrollment information—are not required to develop this notice | Individuals enrolled in the plan | Fully insured group plans meeting the definition of a "[covered entity](http://www.hhs.gov/hipaa/for-professionals/covered-entities/)" that create or receive PHI in addition to summary health & enrollment information must provide the notice upon request  Other health plans that are covered entities must provide the notice to new enrollees at the time of enrollment and to covered individuals within 60 days of a material revision to the policy (with special rules for website notice postings); must notify covered individuals of the availability of the notice and how to obtain the notice at least once every 3 years; and must provide it upon request |
| Special Health Care Notices | | |
| **Notice** | **Provide To** | **When Due** |
| [Women's Health & Cancer Rights Act (WHCRA) Notices](#WHCRA) | Group health plan participants & beneficiaries | Upon enrollment in a plan that provides coverage for medical and surgical benefits related to a mastectomy, and annually thereafter |
| [Mental Health Parity & Addiction Equity Act (MHPAEA) Disclosure](#MHPAEA) | Any current or potential group health plan participant, beneficiary, or contract provider | Upon request for a plan offering medical/surgical benefits and mental health or substance use disorder benefits  **Note**: Certain plans that are [exempt from the requirements](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html#Key%20changes%20made%20by%20MHPAEA) under the MHPAEA based on increased cost may be subject to [alternative disclosure rules](http://www.ecfr.gov/cgi-bin/text-idx?SID=4416ce1678ce60028fd914de5d05f340&node=29:9.1.3.12.16.3.20.2&rgn=div8) |

|  |  |  |
| --- | --- | --- |
| Special Health Care Notices (continued) | | |
| **Notice** | **Provide To** | **When Due** |
| [Employer Children's Health Insurance Program (CHIP) Notice](#CHIP) | All employees in states with group health plan premium assistance | Annually before the start of each plan year (may be provided concurrently with the SPD or other materials notifying the employee of plan eligibility, or in connection with an open season or election process conducted under the plan) |
| [Michelle's Law Notice](#Michelle) | Group health plan participants | With any notice regarding a requirement for certification of student status under a plan that bases eligibility for coverage on student status (and that provides dependent coverage [beyond age 26](http://www.dol.gov/elaws/ebsa/health/employer/657.asp)) |
| [Newborns' and Mothers' Health Protection Act Notice](#Newborns) | Group health plan participants | Must be included in the SPD for a plan providing maternity or newborn infant coverage |
| [Medicare Part D Creditable Coverage Disclosure Notice](#MedicareCred)  or  [Medicare Part D Non-Creditable Coverage Disclosure Notice](#MedicareNonCred) | [Medicare-eligible individuals](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/CreditableCoverage/) (including certain dependents) who are offered prescription drug coverage under the employer's group health plan | Annually prior to October 15th, upon request, and at various [other times](http://www.law.cornell.edu/cfr/text/42/423.56#f) as required under the law  An [online disclosure](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html#TopOfPage) to the Centers for Medicare & Medicaid Services (CMS) is also required annually, no later than 60 days from the beginning of a plan year, and at certain [other times](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html) |
| [Genetic Information Nondiscrimination Act (GINA) Disclosures](#GINA) | Entities from whom requests for health-related information are made | Whenever an applicant or employee is sent to a health care provider for a medical examination by an employer with 15 or more employees  An additional "warning" is required when requests for health-related information are made by employers with 15 or more employees (e.g., to support an employee's request for reasonable accommodation or a request for sick leave), but only if the request for medical documentation is made in a way that is likely to result in receipt of genetic information |

|  |  |  |
| --- | --- | --- |
| Special Health Care Notices (continued) | | |
| **Notice** | **Provide To** | **When Due** |
| [ADA Notice Regarding Wellness Program](#ADAWellness)  **Note**: This notice requirement is effective as of the first day of the plan year that begins **on or after January 1, 2017** | All employees offered participation in a wellness program that collects employee health information | Must be provided before the employee provides any health information, with enough time for the employee to decide whether to participate in the program |

Note: The information and materials herein are provided for general information purposes only and have been taken from sources believed to be reliable, but there is no guarantee as to its accuracy. © 2016 HR 360, Inc. | Last Updated: September 22, 2016

**SUMMARY OF MATERIAL MODIFICATIONS/****SUMMARY OF MATERIAL REDUCTION IN COVERED SERVICES TO  [NAME OF WELFARE BENEFIT PLAN]**

**This Summary of Material Modifications (“SMM”) modifies some of the information contained in the Summary Plan Description (“SPD”) for the  [Name of Welfare Benefit Plan]  (the “Plan”) that describes the Plan as of  [Date] .**

Note: In the event of any discrepancy between this SMM and the Summary Plan Description, the provisions of this SMM will govern.

**Modification(s)**

Important changes under the Plan will go into effect on  [Effective Date] . In particular, coverage for  [Types of Benefits]  shall be amended as follows:

 [Nature of Changes]

If you have questions about these changes in benefits, please contact your Plan Administrator at  [Phone Number of Plan Administrator] .

**HEALTH INSURANCE EXCHANGE NOTICE**

***For Employers Who Offer a Health Plan to Some or All Employees (expires 1/31/17)***

**New Health Insurance Marketplace Coverage**

**Options and Your Health Coverage**

**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 employment­based 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]](#footnote-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

[Insert contact here]

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [**HealthCare.gov**](http://www.healthcare.gov/) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

|  |  |  |
| --- | --- | --- |
| 3. Employer name | 4. Employer Identification Number (EIN) | |
| 5. Employer address | 6. Employer phone number | |
| 7. City | 8. State | 9. ZIP code |
| 10. Who can we contact about employee health coverage at this job? | | |
| 11. Phone number (if different from above) | 12. Email address | |

Here is some basic information about health coverage offered by this employer:

* As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

* With respect to dependents:

We do offer coverage. Eligible dependents are:

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [**HealthCare.gov**](http://www.healthcare.gov/)  will guide you through the process. Here's the employer information you'll enter when you visit [**HealthCare.gov**](http://www.healthcare.gov/) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

|  |
| --- |
| 13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**  **Yes** (Continue)  13a. If the employee is not eligible today, including as a result of a waiting or probationary period,  when is the employee eligible for coverage?  [mm/dd/yyyy]   (Continue)  **No** (STOP and return this form to employee) |

|  |
| --- |
| 14. Does the employer offer a health plan that meets the minimum value standard\*?  Yes (Go to question 15) No (STOP and return form to employee) |
| 15. For the lowest-cost plan that meets the minimum value standard[[2]](#footnote-2)\***offered only to the employee**  (don't include family plans): If the employer has wellness programs, provide the premium that the  employee would pay if he/ she received the maximum discount for any tobacco cessation  programs, and didn't receive any other discounts based on wellness programs.  a. How much would the employee have to pay in premiums for this plan? $  b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly Yearly |

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ \_\_\_\_\_\_\_\_\_\_\_

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

**HEALTH INSURANCE EXCHANGE NOTICE**

***For Employers Who Do Not Offer a Health Plan (expires 1/31/17)***

**New Health Insurance Marketplace Coverage**

**Options and Your Health Coverage**

**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 employment­based 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.[[3]](#footnote-3)

**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?**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [**HealthCare.gov**](http://www.healthcare.gov/)  for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

|  |  |  |
| --- | --- | --- |
| 3. Employer name | 4. Employer Identification Number (EIN) | |
| 5. Employer address | 6. Employer phone number | |
| 7. City | 8. State | 9. ZIP code |
| 10. Who can we contact about employee health coverage at this job? | | |
| 11. Phone number (if different from above) | 12. Email address | |

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

**SUMMARY OF BENEFITS AND COVERAGE**

**(Note: A** [**different template**](https://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html) **is available for use on or after April 1, 2017)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** | **Plan Type:**

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | **$** |  |
| **Are there other**  **deductibles for specific services?** | **$** |  |
| **Is there an out–of–pocket limit on my expenses?** | **$** |  |
| **What is not included in**  **the out–of–pocket limit?** |  |  |
| **Is there an overall annual limit on what the plan pays?** |  |  |
| **Does this plan use a network of providers?** |  |  |
| **Do I need a referral to see a specialist?** |  |  |
| **Are there services this plan doesn’t cover?** |  |  |

|  |  |
| --- | --- |
| **Exclamation** | **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.[insert]** or by calling **1-800-[insert]**. |

**Questions:** Call **1-800-[insert]** or visit us at **www.[insert] .**If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call **1-800-[insert]** to request a copy.

**1 of 6**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** | **Plan Type:**

|  |  |
| --- | --- |
| **Exclamation** | * **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. * **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**. * The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) * This plan may encourage you to use **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Common  Medical Event** | **Services You May Need** | **Your Cost If You Use an**  **In-network Provider** | **Your Cost If You Use an**  **Out-of-network Provider** | **Limitations & Exceptions** |
| **If you visit a health care**  **provider’s office or clinic** | Primary care visit to treat an injury or illness |  |  |  |
| Specialist visit |  |  |  |
| Other practitioner office visit |  |  |  |
| Preventive care/screening/immunization |  |  |  |
| **If you have a**  **test** | Diagnostic test (x-ray, blood work) |  |  |  |
| Imaging (CT/PET scans, MRIs) |  |  |  |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at   www.[insert] . | Generic drugs |  |  |  |
| Preferred brand drugs |  |  |  |
| Non-preferred brand drugs |  |  |  |
| Specialty drugs |  |  |  |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) |  |  |  |
| Physician/surgeon fees |  |  |  |

**Questions:** **Call** **1-800-[insert]  or visit us at** **www.[insert] .**

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call **1-800-[insert]** to request a copy.

**2 of 6**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** | **Plan Type:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Common  Medical Event** | **Services You May Need** | **Your Cost If You Use an**  **In-network Provider** | **Your Cost If You Use an**  **Out-of-network Provider** | **Limitations & Exceptions** |
| **If you need**  **immediate medical attention** | Emergency room services |  |  |  |
| Emergency medical  transportation |  |  |  |
| Urgent care |  |  |  |
| **If you have a**  **hospital stay** | Facility fee (e.g., hospital room) |  |  |  |
| Physician/surgeon fee |  |  |  |
| **If you have**  **mental health,**  **behavioral health, or**  **substance abuse needs** | Mental/Behavioral health  inpatient services |  |  |  |
| Substance use disorder  outpatient services |  |  |  |
| Substance use disorder inpatient services |  |  |  |
| **If you are pregnant** | Prenatal and postnatal care |  |  |  |
| Delivery and all inpatient  services |  |  |  |
| **If you need help recovering or have other special health needs** | Home health care |  |  |  |
| Rehabilitation services |  |  |  |
| Habilitation services |  |  |  |
| Skilled nursing care |  |  |  |
| Durable medical equipment |  |  |  |
| Hospice service |  |  |  |
| **If your child needs dental or eye care** | Eye exam |  |  |  |
| Glasses |  |  |  |
| Dental check-up |  |  |  |

**Excluded Services & Other Covered Services:**

|  |
| --- |
| **Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)** |
|  |
|  |
|  |

**Questions:** Call **1-800-[insert]** or visit us at **www.[insert] .**If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call **1-800-[insert]** to request a copy.

**3 of 6**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** | **Plan Type:**

|  |
| --- |
| **Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)** |
|  |

**Your Rights to Continue Coverage:**

 [insert applicable information from instructions]

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:  [insert applicable information] .

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy** **[does/does not]  provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage** **[does/does not]  meet the minimum value standard for the benefits it provides.**

[Insert heading and applicable tagline(s):

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al [insert a telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码  [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'  [insert telephone number].]

*------------To see examples of how this plan might cover costs for a sample medical situation, see the next page.------------*

**Questions:** Call **1-800-[insert]** or visit us at **www.[insert] .**If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call **1-800-[insert]** to request a copy.

**4 of 6**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Coverage Examples**  **Coverage for:** | **Plan Type:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **About these Coverage Examples:**  These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.  **This is  not a cost estimator.**  Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.  See the next page for important information about these examples. | **Having a baby** (normal delivery) | | | **Managing type 2 diabetes** (routine maintenance of  a well-controlled condition) | | |
| ◼ **Amount owed to providers:** $7,540  ◼ **Plan pays** $  ◼ **Patient pays** $ | | | ◼ **Amount owed to providers:** $5,400  ◼ **Plan pays** $  ◼ **Patient pays** $ | | |
| **Sample care costs:** | | | **Sample care costs:** | | |
| Hospital charges (mother) | | $2,700 | Prescriptions | | $2,900 |
| Routine obstetric care | | $2,100 | Medical Equipment and Supplies | | $1,300 |
| Hospital charges (baby) | | $900 | Office Visits and Procedures | | $700 |
| Anesthesia | | $900 | Education | | $300 |
| Laboratory tests | | $500 | Laboratory tests | | $100 |
| Prescriptions | | $200 | Vaccines, other preventive | | $100 |
| Radiology | | $200 | **Total** | | **$5,400** |
| Vaccines, other preventive | | $40 |  | | |
| **Total** | | **$7,540** |
| **Patient pays:** | | | **Patient pays:** | | |
| Deductibles | $ | | Deductibles | $ | |
| Copays | $ | | Copays | $ | |
| Coinsurance | $ | | Coinsurance | $ | |
| Limits or exclusions | $ | | Limits or exclusions | $ | |
| **Total** | $ | | **Total** | $ | |

**Questions:** Call **1-800-[insert]** or visit us at **www.[insert] .**If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at**www.[insert]** or call **1-800-[insert]** to request a copy.

**5 of 6**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Period: [See Instructions]**

**Coverage Examples**  **Coverage for:** | **Plan Type:**

**Questions and answers about the Coverage Examples:**

|  |  |  |
| --- | --- | --- |
| **What are some of the assumptions behind the Coverage Examples?**   * Costs don’t include **premiums**. * Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan. * The patient’s condition was   not an excluded or preexisting condition.   * All services and treatments started and ended in the same coverage period. * There are no other medical expenses for any member covered under this plan. * Out-of-pocket expenses are based only on treating the condition in the example. * The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher. | **What does a Coverage Example show?**  For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited. | **Can I use Coverage Examples to compare plans?**  **✓Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the planprovides. |
| **Does the Coverage Example predict my own care needs?**  **🗶 No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors. | **Are there other costs I should consider when comparing plans?**  **✓Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses. |
| **Does the Coverage Example predict my future expenses?**  **🗶No.** Coverage Examples are **not** cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows. |

**Questions:** Call **1-800-[insert]** or visit us at **www.[insert] .**If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call **1-800-[insert]** to request a copy.

**6 of 6**

**GRANDFATHER NOTICE**

This  [group health plan or health insurance issuer]  believes this  [plan or coverage]  is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your  [plan or policy]  may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at  [insert contact information] . [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal government plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov)]

**NOTICE OF PATIENT PROTECTIONS**

*For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:*

 [Name of group health plan or health insurance issuer]  generally  [requires/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. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation,  [name of group health plan or health insurance issuer]  designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the  [plan administrator or issuer]  at  [insert contact information] .

*For plans and issuers that require or allow for the designation of a primary care provider for a child, add:*

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

*For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:*

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

**NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within  [insert "30 days" or any longer period that applies under the plan]  after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within  [insert "30 days" or any longer period that applies under the plan]  after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact  [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative] .

**WELLNESS PROGRAM DISCLOSURE**

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at  [insert contact information]  and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

**NOTICE OF PRIVACY PRACTICES**

**[Covered Entity's Name]** **[Covered Entity's Address]**

**[Covered Entity's Website]**

**[Privacy Official's phone, e-mail**

**and other contact information]**

**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 paper or electronic medical record
* Correct your paper or electronic medical record
* 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

**Your Choices**

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

* Tell family and friends about your condition
* Provide disaster relief
* Include you in a hospital directory
* Provide mental health care
* Market our services and sell your information
* Raise funds

**Our Uses and Disclosures**

We may use and share your information as we:

|  |
| --- |
| * Treat you * Run our organization * Bill for your services * Help with public health and safety issues * Do research * Comply with the law * Respond to organ and tissue donation requests * Work with a medical examiner or funeral director * Address workers’ compensation, law enforcement, and other government requests * Respond to lawsuits and legal actions |

**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 an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is 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 say “yes” to all reasonable requests.

**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.
* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**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 at  [contact info] .
* 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 your care
* Share information in a disaster relief situation
* Include your information in a hospital directory

*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
* Most sharing of psychotherapy notes

In the case of fundraising:

* We may contact you for fundraising efforts, but you can tell us not to contact you again.

**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.

**Treat you**

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

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**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](http://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**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

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](http://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, in our office, and on our web site.

**Other Instructions for Notice**

* Insert Effective Date of this Notice
* Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
* Insert any special notes that apply to your entity’s practices such as “we never market or sell personal information.”
* The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, “We will never share any substance abuse treatment records without your written permission.” Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
* If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
* If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, “This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area.”

**WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES**

***Enrollment Notice***

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:  [insert deductibles and coinsurance applicable to these benefits] . If you would like more information on WHCRA benefits, call your plan administrator  [insert phone number] .

***Annual Notice***

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at  [insert phone number]  for more information.

**MENTAL HEALTH PARITY & ADDICTION EQUITY ACT DISCLOSURE**

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the  [Name of Plan]  with respect to mental health or substance use disorder benefits, please contact your plan administrator at  [insert phone number] .

**EMPLOYER CHIP NOTICE (Expires 10/31/16)**

**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**](http://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**](http://www.askebsa.dol.gov) or call **1-866-444-EBSA** **(3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –**

|  |  |
| --- | --- |
| **ALABAMA – Medicaid** | **FLORIDA – Medicaid** |
| Website: <http://myalhipp.com/>  Phone: 1-855-692-5447 | Website: <http://flmedicaidtplrecovery.com/hipp/>  Phone: 1-877-357-3268 |
| **ALASKA – Medicaid** | **GEORGIA – Medicaid** |
| The AK Health Insurance Premium Payment Program  Website: <http://myakhipp.com/>  Phone: 1-866-251-4861  Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx> | Website: <http://dch.georgia.gov/medicaid>  - Click on Health Insurance Premium Payment (HIPP)  Phone: 404-656-4507 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid** |
| Website: <http://myarhipp.com/>  Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64  Website: [http://www.hip.in.gov](http://www.hip.in.gov/)  Phone: 1-877-438-4479  All other Medicaid  Website: [http://www.indianamedicaid.com](http://www.indianamedicaid.com/)  Phone 1-800-403-0864 |

|  |  |
| --- | --- |
| **COLORADO – Medicaid** | **IOWA – Medicaid** |
| Medicaid Website: <http://www.colorado.gov/hcpf>  Medicaid Customer Contact Center: 1-800-221-3943 | Website: <http://www.dhs.state.ia.us/hipp/>  Phone: 1-888-346-9562 |

|  |  |
| --- | --- |
| **KANSAS – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: <http://www.kdheks.gov/hcf/>  Phone: 1-785-296-3512 | Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>  Phone: 603-271-5218 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: <http://chfs.ky.gov/dms/default.htm>  Phone: 1-800-635-2570 | Medicaid Website:  <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>  Medicaid Phone: 609-631-2392  CHIP Website: <http://www.njfamilycare.org/index.html>  CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>  Phone: 1-888-695-2447 | Website: <http://www.nyhealth.gov/health_care/medicaid/>  Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>  Phone: 1-800-442-6003  TTY: Maine relay 711 | Website: <http://www.ncdhhs.gov/dma>  Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website: <http://www.mass.gov/MassHealth>  Phone: 1-800-462-1120 | Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>  Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: <http://mn.gov/dhs/ma/>  Phone: 1-800-657-3739 | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org/)  Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  Phone: 573-751-2005 | Website: <http://healthcare.oregon.gov/Pages/index.aspx>  <http://www.oregonhealthcare.gov/index-es.html>  Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  Phone: 1-800-694-3084 | Website: <http://www.dhs.pa.gov/hipp>  Phone: 1-800-692-7462 |

|  |  |
| --- | --- |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website: <http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx>  Phone: 1-855-632-7633 | Website: <http://www.eohhs.ri.gov/>  Phone: 401-462-5300 |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** | |
| Medicaid Website: <http://dwss.nv.gov/>  Medicaid Phone: 1-800-992-0900 | Website: [http://www.scdhhs.gov](http://www.scdhhs.gov/)  Phone: 1-888-549-0820 | |

|  |  |
| --- | --- |
| **SOUTH DAKOTA - Medicaid** | **WASHINGTON – Medicaid** |
| Website: [http://dss.sd.gov](http://dss.sd.gov/)  Phone: 1-888-828-0059 | Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>  Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: <http://gethipptexas.com/>  Phone: 1-800-440-0493 | Website: <http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx>  Phone: 1-877-598-5820, HMS Third Party Liability |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Website:  Medicaid: <http://health.utah.gov/medicaid>  CHIP: <http://health.utah.gov/chip>  Phone: 1-877-543-7669 | Website:  <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>  Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: <http://www.greenmountaincare.org/>  Phone: 1-800-250-8427 | Website: <https://wyequalitycare.acs-inc.com/>  Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** |  |
| Medicaid Website: <http://www.coverva.org/programs_premium_assistance.cfm>  Medicaid Phone: 1-800-432-5924  CHIP Website: <http://www.coverva.org/programs_premium_assistance.cfm>  CHIP Phone: 1-855-242-8282 |  |

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare &Medicaid Services

[**www.dol.gov/ebsa**](http://www.dol.gov/ebsa) [**www.cms.hhs.gov**](http://www.cms.hhs.gov/)

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

**MICHELLE'S LAW NOTICE**

***Plan Administrator Note:*** *This notice must be provided with any notice regarding a requirement for certification of student status for coverage under the plan.*

*Note: Pursuant to Michelle’s Law, you are being provided with the following notice because the* *[Employer Name]  group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.*

When a dependent child loses student status for purposes of  [Employer Name]  group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the  [Employer Name]  group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the  [Employer Name]  group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

* The  [Employer Name]  group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
* [Insert any other permissible eligibility conditions here, such as being enrolled in the plan immediately prior to the first day of the medically necessary leave of absence] .

To obtain additional information, please contact:  [   ] .

**NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).  [Plans subject to State law requirements will need to prepare statements describing any applicable State law]

**MEDICARE PART D CREDITABLE COVERAGE NOTICE**

**Important Notice from [Insert Name of Entity] 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** **[Insert Name of Entity]  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. **[Insert Name of Entity]  has determined that the prescription drug coverage offered by the** **[Insert Name of 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 15th to December 7th.

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.

**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  [Insert Name of Entity]  coverage will  [or will not]  be affected.  [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity’s plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity’s plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (avail[able at http://www.cms.hhs.gov/CreditableCoverage/),](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  [Insert Name of Entity]  coverage, be aware that you and your dependents  [will or will not] [Medigap issuers must insert *"will not"*] be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with  [Insert Name of Entity]  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 the person listed below for further information [or call  [Insert Alternative Contact]  at  [(XXX) XXX-XXXX] . **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  [Insert Name of Entity]  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](http://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](http://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).**

**[Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]**

|  |
| --- |
| Medicare Eligible Individual’s Name:  [Insert Full Name of Medicare Eligible Individual]  Individual’s DOB or unique Member ID:  [Insert Individual's Date of Birth] , or  [Member ID]  The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:  **From:**  [Insert MM/DD/YY]  **To:**  [Insert MM/DD/YY]  **From:**  [Insert MM/DD/YY]  **To:** [Insert MM/DD/YY] |

Date:  [Insert MM/DD/YY]

Name of Entity/Sender:  [Insert Name of Entity]

Contact--Position/Office:  [Insert Position/Office]

Address:  [Insert Street Address, City, State & Zip Code of Entity]

Phone Number:  [Insert Entity Phone Number]

**MEDICARE PART D NON-CREDITABLE COVERAGE NOTICE**

**Important Notice From** **[Insert Name of Entity]  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** **[Insert Name of Entity]  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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are three important things you need to know about your current coverage and Medicare’s prescription drug coverage:**

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **[Insert Name of Entity]  has determined that the prescription drug coverage offered by the** **[Insert Name of Plan]  is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the** **[Insert Name of Plan] . This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from** **[Insert Name of Plan] . However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

**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 15TH to December 7th.

[***INSERT IF EMPLOYER/UNION SPONSORED GROUP PLAN***: However, if you decide to drop your current coverage with  [Insert Name of Entity] , since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under  [Insert Name of Plan] .]

[***INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE***: Since you are losing creditable prescription drug coverage under the  [Insert Name of Plan] , you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

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

Since the coverage under  [Insert Name of Plan] , is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that’s creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**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  [Insert Name of Entity]  coverage will  [or will not]  be affected.  [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity’s plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity’s plan will end for the individual and all covered dependents, etc.). [*See* pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at [http://www.cms.hhs.gov/CreditableCoverage/),](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  [Insert Name of Entity]  coverage, be aware that you and your dependents will  [or will not]   [Medigap issuers must insert *"will not"*]  be able to get this coverage back.

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

Contact the person listed below for further information  [or call  [Insert Alternative Contract] at [(XXX) XXX-XXXX]   . **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  [Insert Name of Entity]  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](http://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](http://www.socialsecurity.gov/), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

 **[Optional Insert – If a beneficiary has had creditable coverage under the entities plan for any period of time since May 15, 2006, entities can insert the following information box if they choose to provide a personalized disclosure notice.]**

|  |
| --- |
| Medicare Eligible Individual’s Name:  [Insert Full Name of Medicare Eligible Individual]  Individual’s DOB or unique Member ID:  [Insert Individual's Date of Birth] , or  [Member ID]  The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:  **From:**  [Insert MM/DD/YY]  **To:**  [Insert MM/DD/YY]  **From:**  [Insert MM/DD/YY]  **To:**[Insert MM/DD/YY] |

Date:  [Insert MM/DD/YY]

Name of Entity/Sender:  [Insert Name of Entity]

Contact--Position/Office:  [Insert Position/Office]

Address:  [Insert Street Address, City, State & Zip Code of Entity]

Phone Number:  [Insert Entity Phone Number]

**GINA DISCLOSURES**

***General Disclosure***

**GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008**

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

***Additional "Warning" Language***

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

## ADA NOTICE REGARDING WELLNESS PROGRAM

 [Name of wellness program]  is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for  [be specific about the conditions for which blood will be tested] .You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of  [indicate the incentive]  for  [specify criteria] . Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive  [the incentive] .

Additional incentives of up to  [indicate the additional incentives]  may be available for employees who participate in certain health-related activities  [specify activities, if any]  or achieve certain health outcomes  [specify particular health outcomes to be achieved, if any] . If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting  [name]  at  [contact information] .

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as  [indicate services that may be offered] . You also are encouraged to share your results or concerns with your own doctor.

## Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and  [name of employer]  may use aggregate information it collects to design a program based on identified health risks in the workplace,  [name of wellness program]  will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are)  [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"]  in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.  [Specify any other or additional confidentiality protections if applicable.]  Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact  [insert name of appropriate contact]  at  [contact information] .

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. [↑](#footnote-ref-1)
2. \* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986) [↑](#footnote-ref-2)
3. 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. [↑](#footnote-ref-3)