Deery Automotive Group

Group Health Plan Notices

Prepared by:



Insurance & Benefit Solutions

Group Contact:

Phil Waniorek

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 6-30-2023)

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?

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.

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 Deery Automotive Group	4. Employ 42-112247	yer Identification Number (EIN) 78
5. Employer address 7404 University Ave.	6. Employ	yer phone number ₃₁₉₋₂₇₇₋₄₅₀₀
7. City Cedar Falls	8. State IA	9. ZIP code 50613
10. Who can we contact about employee health coverage at this job?	Jordan Zaputil	
11. Phone number (if different from above) 12. Email ad jlzaputil@d	dress eeryautogroup.com	
Here is some basic information about health coverage offered by •As your employer, we offer a health plan to: X All employees. Eligible employees are: All full-time employees working at least 30 hours per week		
Some employees. Eligible employees are:		
With respect to dependents: We do offer coverage. Eligible dependents a All eligible dependents, of eligible employees, under the ag can stay on the plan longer.		mstances, an eligible dependent
☐ We do not offer coverage.		
If checked, this coverage meets the minimum value standard be affordable, based on employee wages.	I, and the cost of this co	overage to you is intended to
** Even if your employer intends your coverage to be aff discount through the Marketplace. The Marketplace w to determine whether you may be eligible for a premiu week to week (perhaps you are an hourly employee or employed mid-year, or if you have other income losses.	ill use your household ind um discount. If, for exam r you work on a commiss	come, along with other factors, nple, your wages vary from sion basis), if you are newly

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit 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 next 3 months?	jible in
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)	е
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* 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/s received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based 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 Year	she d on
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	

[•] 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)

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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.

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nployer name Deery Automotive Group		4. Employer Identification Number (EIN) 42-1122478		
5. Employer address 7404 University Ave.			6. Employer phone number 319-277-4500	
7. City Cedar Falls	8. State IA		9. ZIP code 50613	
10. Who can we contact at this job? Jordan Zaputil				
11. Phone number (if different from above) jlzaputil@deeryautogroup.com				

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.

Important Notice from Deery Automotive Group 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 Deery Automotive Group 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. Deery Automotive Group has determined that the prescription drug coverage offered by the Wellmark of lowa 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 **Deery Automotive Group** coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current **Deery Automotive Group** coverage, be aware that you and your dependents will 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 **Deery Automotive Group** 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 Phil Waniorek Jr. at (563) 387-0789. **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 **Deery Automotive Group** 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).

Date:

01/01/2024

Name of Entity/Sender:

Deery Automotive Group

Contact--Position/Office:

Jordan Zaputil - Payroll Office

Address:

7404 University Ave.; Cedar Falls, IA 50613

Phone Number:

319-277-4500

Newborn's Act Disclosure

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).

Women's Health and Cancer Rights Act (WHCRA)

On October 21, 1998 Congress passed a bill called the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Surgery/reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications during all stages of mastectomy, including lymph edemas in addition, the plan may not:
- · interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact your HR Department.

Initial Notice of Your HIPAA Special Enrollment Rights

Loss of Other Coverage: If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption: 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/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Termination of Medicaid or Children's Health Insurance Program (CHIP) Coverage: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enrollyourself and your dependents in this plan if you or your dependents lose eligibility for that othercoverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Eligibility for Employment Assistance under Medicare or CHIP: If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

AT ADAMA Made it	CALIFORNIA MARCIA
ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/	Website:
Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program
	http://dhcs.ca.gov/hipp
	Phone: 916-445-8322
	Fax: 916-440-5676
	Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	COLORADO-Health First Colorado
	(Colorado's Medicaid Program) & Child
	Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program	Health First Colorado Website:
Website: http://myakhipp.com/	https://www.healthfirstcolorado.com/
Phone: 1-866-251-4861	Health First Colorado Member Contact Center:
Email: <u>CustomerService@MyAKHIPP.com</u>	1-800-221-3943/ State Relay 711
Medicaid Eligibility:	CHP+: https://www.colorado.gov/pacific/hcpf/child-health-
https://health.alaska.gov/dpa/Pages/default.aspx	<u>plan-plus</u>
	CHP+ Customer Service: 1-800-359-1991/ State Relay 711
	Health Insurance Buy-In Program (HIBI):
	https://www.colorado.gov/pacific/hcpf/health-insurance-
	<u>buy-program</u>
	HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myarhipp.com/	Website:
Phone: 1-855-MyARHIPP (855-692-7447)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove
	ry.com/hipp/index.html
	Phone: 1-877-357-3268

GEORGIA-Medicaid MASSACHUSETTS-Medicaid and CHIP GA HIPP Website: https://medicaid.georgia.gov/health-Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 TTY: (617) 886-8102 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-programreauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2 INDIANA-Medicaid MINNESOTA-Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: Website: http://www.in.gov/fssa/hip/ https://mn.gov/dhs/people-we-serve/children-and-Phone: 1-877-438-4479 families/health-care/health-care-programs/programs-and-All other Medicaid services/other-insurance.isp Website: https://www.in.gov/medicaid/ Phone: 1-800-657-3739 Phone 1-800-457-4584 MISSOURI-Medicaid IOWA-Medicaid and CHIP (Hawki) Medicaid Website: Website: https://dhs.iowa.gov/ime/members http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Medicaid Phone: 1-800-338-8366 Phone: 573-751-2005 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562 KANSAS-Medicaid MONTANA-Medicaid Website: https://www.kancare.ks.gov/ Website: Phone: 1-800-792-4884 http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov KENTUCKY-Medicaid NEBRASKA-Medicaid Kentucky Integrated Health Insurance Premium Payment Website: http://www.ACCESSNebraska.ne.gov Program (KI-HIPP) Website: Phone: 1-855-632-7633 https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Lincoln: 402-473-7000 Omaha: 402-595-1178 Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/ index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov LOUISIANA-Medicaid NEVADA-Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Medicaid Website: http://dhcfp.nv.gov Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-Medicaid Phone: 1-800-992-0900 5488 (LaHIPP) **MAINE-Medicaid** NEW HAMPSHIRE-Medicaid Enrollment Website: Website: https://www.dhhs.nh.gov/programshttps://www.maine.gov/dhhs/ofi/applications-forms services/medicaid/health-insurance-premium-program Phone: 1-800-442-6003 Phone: 603-271-5218 TTY: Maine relay 711 Toll free number for the HIPP program: 1-800-852-3345, ext 5218 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	TEXAS-Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	UTAH-Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	VERMONT-Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	VIRGINIA-Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	WASHINGTON-Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	WEST VIRGINIA-Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	WISCONSIN-Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	WYOMING-Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272) U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE **ENTITLEMENTS**

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

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

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

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

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

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

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

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

ELIGIBILITY REQUIREMENTS

BENEFITS &

PROTECTIONS

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

- Have worked for the employer for at least 12 months:
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

REQUESTING LEAVE

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

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

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

EMPLOYER RESPONSIBILITIES

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

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

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

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



For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division



IMPORTANT - Notice of Privacy Practices

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

If you have any questions about this notice, please contact our privacy officer. This person can be contacted by phone during normal working hours at: (563) 387-0789.

Protected Health Information (PHI) is defined as information that would include demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a group health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices.

We are required to abide by the terms of this Notice of Privacy Practices. We also reserve the right to change this Notice at any time. If a change is made to this Notice, a copy of the revised Notice will be sent to all individuals covered under the plan at that time. Any change to this Notice will apply to all PHI that we are maintaining at that time.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment, Payment and Health Care Operations

Federal law allows a group health plan to use and disclose PHI, for the purpose of treatment, payment and health care operations, without your consent or authorization. Examples of the uses and disclosures that we, as a group health plan, may make under each section are listed below:

Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a group health plan we do not provide treatment.

Payment. Payment refers to when a group health plan collects premiums and pays claims under the plan for health care services you receive. Examples of uses and disclosures under this section include providing PHI in the billing, collection and payment of all premiums and fees to business associates of the plan such as PPO Networks, UR Companies, Prescription Drug Card Companies and Reinsurance Carriers; the sending of PHI to a medical review company to determine the medical necessity or experimental status of a treatment or procedure; sharing PHI with other insurance carriers or claims payors to determine coordination of benefits or to settle any subrogation claims; providing PHI to the plan's UR Company for precertification or case management services; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.

Health Care Operations. Health Care Operations refer to the basic functions necessary to operate a group health plan. Examples of uses and disclosures under this section include the disclosure of PHI to underwriters for the purpose of determining premium rates and to provide reinsurance quotes to

the plan; disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to the plan; the use of PHI to determine the cost impact of benefit design changes; doing a quality assessment study of the performance of the plan or the performance of one of the plan's vendors; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the plan; and use of PHI in general data analysis used in the long term management and planning for the plan and company.

Other Uses and Disclosures Allowed Without Authorization

Federal law allows a group health plan to use and disclose PHI, without your consent or authorization, in the following ways:

- > To you, the covered individual.
- > To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.
- > To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- > To a Business Associate as part of a contracted agreement to perform services for the group health plan.
- > To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses.
- > In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- > As required for law enforcement purposes. For example to notify authorities of a criminal act.
- As required to comply with Workers' Compensation or other similar programs established by law.
- > To the Plan Sponsor, as necessary to carry out administrative functions of the plan such as evaluating renewal quotes for reinsurance of the plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the plan is case managing.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received

and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures

You have the right to request that the plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

The plan is not required to agree to a restriction that you request. However, if the plan does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications

You have the right to request confidential communications. This means you may ask that we communicate with you by alternative means or at alternative locations. We will accommodate such a request if it is reasonable and if you state, in writing, that disclosure of the information in the ordinary manner could endanger you. You must make such a request in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information

You have the right to inspect and to obtain a copy of your own PHI in a designated record set. A designated record set might include information related to enrollment, payment, claims adjudication, and case or medical management. Federal law does prohibit you from having access to the following records: psychotherapy notes; information complied in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed in this notice.

Right to Amend Protected Health Information

You have the right to request that the plan change or correct PHI that the plan maintains about you. The plan may deny your request for amendment if it determines that the PHI was not created by the plan, is not part of a designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the plan after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive a Paper Copy of this Notice

You have the right to request additional copies of this Notice, upon request, regardless of whether you have already received one electronically or in hard copy. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the plan or the Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed in this Notice. The plan will not retaliate against you for filing a complaint.

PRIVACY CONTACT

You can contact the Privacy Contact through BENEFITS, INC. at (563) 387-0789. Ask for the Privacy Officer and if he is not available, please leave a voice mail message and he will return the call as soon as possible. You can mail your requests to:

BENEFITS, INC. Privacy Officer P.O. Box 485 Decorah, IA 52101

EFFECTIVE DATE OF THIS NOTICE

This Notice becomes effective on April 15, 2006.



Insurance & Benefit Solutions

P.O. Box 410 Decorah, IA 52101

Toll Free (877) 461-1424 Phone Number (563) 387-0789 Fax Number (563) 387-0682

www.benefitsolutions.us