Compliance Notices

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Notice of Special Enrollment Rights for Health Plan Coverage

As you know, if you have declined enrollment in SPARC's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

SPARC will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the SPARC group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Important Notice to Employees from SPARC About Creditable 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 SPARC GROUP LLC 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:

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.

SPARC GROUP LLC, has determined that the prescription drug coverage offered by:

(a) Express Scripts Prescription Drug Plan included in the Anthem CDHP and PPO plans'; (b) Kaiser Permanente HMO (California Only); and (c) MCS Puerto Rico (Puerto Rico Only) are all, 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 SPARC GROUP LLC, coverage will be affected. If you do decide to join a Medicare drug plan and drop your current SPARC GROUP LLC coverage, be aware that you and your dependents may not be able to get this coverage back except in limited circumstances.

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 SPARC GROUP LLC, 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 Plan Administrator at benefits@sparcgroup.com. 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 SPARC GROUP LLC, 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).

Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance

Updated Guidance – September 18, 2009

I. INTRODUCTION

CMS issued General Creditable Coverage guidance in May 2005 and issued an updated version on May 15, 2006. This guidance supersedes the previous guidance issued in May 2005, May 15, 2006 and on February 15, 2007. The following changes are being made in section III entitled "Policy Guidance":

- Changes to the required data elements in the Model Personalized Disclosure Notice/Statement.

In addition to the May 2005, May 2006 and February 15, 2007 guidance, CMS issued guidance on the Disclosure to CMS requirements along with the Disclosure to CMS form in January 2006 and posted the Disclosure to CMS Form Instructions and Screen Shots on September 25, 2007. The Disclosure to CMS guidance, instructions and on-line form can be found on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

Disclosure of Creditable Coverage Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. (*See* Part D of Title XVIII of the Social Security Act (Act), referred to here as "Part D" of Medicare.) Prescription drug coverage under Medicare became available starting January 1, 2006.

Regulations to implement Medicare prescription drug coverage were published January 28, 2005 (70 Fed. Reg. 4193). This guidance pertains to section 1860D-13 of the Act, and 42 CFR §423.56. Under those provisions, most entities that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the entity's coverage is "creditable prescription drug coverage" (Disclosure Notice). A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Health plans and other entities that must comply with these provisions are listed in 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/creditablecoverage. However, entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement. Thus, for example, an employer or union that provides prescription drug coverage to retirees through a Part D plan is exempt from the disclosure requirement. *See* 42 CFR §423.56(c).

Disclosure of whether prescription drug coverage is creditable provides Medicare beneficiaries with important information relating to their Medicare Part D enrollment. Beneficiaries who are not covered under creditable prescription drug coverage and who choose not to enroll before the end of their initial enrollment period for Part D may pay a higher premium on a permanent basis if they subsequently enroll in a Part D drug plan.

42 CFR §423.56 establishes certain requirements regarding Disclosure Notices, including rules regarding timing and general content requirements. This guidance

provides additional information concerning those rules, including the form and manner of providing Disclosure Notices. It also addresses several principles relating to the determination of creditable coverage.

II. OVERVIEW OF REGULATORY REQUIREMENTS

Disclosure to CMS

42 CFR §423.56(e) requires all entities described in 42 CFR §423.56(b) to disclose to CMS whether their prescription drug coverage is creditable or non-creditable. The disclosure must be made to CMS on an annual basis, and upon any change that affects whether the coverage is creditable. CMS posted guidance on the timing, format, and the Disclosure to CMS Form on January 4, 2006 and published the Disclosure to CMS Form Instructions and Screen Shots on September 25, 2007. The Disclosure to CMS guidance, instructions and Disclosure to CMS form can be found on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

Disclosure to Medicare Part D Eligible Individuals

The Disclosure Notice must be provided to all Part D eligible individuals who are covered under, or who apply for, the entity's prescription drug coverage. Neither the statute nor the regulations create any exemption based on whether prescription drug coverage is primary or secondary coverage to Medicare Part D. Thus, for example, the Disclosure Notice requirement applies with respect to Medicare beneficiaries who are active employees, disabled, on COBRA, and are retired, as well as Medicare beneficiaries who are covered as spouses or dependents (including those spouses or dependents that may be disabled or on COBRA) under active employee coverage and retiree coverage.

While the entity that provides the coverage is responsible for providing the notice, nothing in the regulation prevents that entity from arranging to have it provided by a third party.

Part D eligible individuals

An individual is a Part D eligible individual if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B; and
2. The individual resides in the service area of a prescription drug plan (PDP) or of a Medicare Advantage plan that provides prescription drug coverage (MA-PD). (For purposes of the Part D regulations, an individual who is living abroad or is incarcerated is not eligible for Part D because he or she is not considered to "reside" in the service area of a Part D plan.)

NOTE: In general; an individual becomes "entitled to" Medicare Part A when the person actually has Part A coverage, and not simply when the person is first eligible. A person has Part A coverage without being subject to monthly Part A premiums if the person has attained age 65 and has monthly social security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability. An individual who is eligible for social security

benefits but has not applied for such benefits becomes entitled to Medicare Part A only upon the filing of an application for Part A benefits.

Information about Medicare Part A and Part B eligibility and enrollment is provided in the CMS publication "Medicare & You" (publication number 10050). This publication is available on line at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf. Medicare beneficiaries should be directed to their local Social Security (or Railroad Retirement) office for questions about when and how to enroll in Medicare.

Enrollment in Part D

The MMA established an Initial Enrollment Period (IEP) for Part D for all Medicare beneficiaries that began on November 15, 2005 and extended through May 15, 2006. After May 15, 2006, the Initial Enrollment Period for Part D is concurrent with the individual's IEP for Part B which is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements for Parts A & B and ends 3 months after the month of first eligibility.

If, by the end of an individual's Initial Enrollment Period for Part D, the individual has not enrolled in a Medicare prescription drug plan and does not have creditable prescription drug coverage for any continuous period of 63 days or longer following the end of the IEP, the individual may have to pay a higher premium charge for late enrollment.

As stated in 42 CFR §423.56(a)(3)(iii), an individual who becomes entitled to Medicare Part A or enrolled in part B for a retroactive effective date has an initial enrollment beginning with the month in which notification of the Medicare determination is received and ending on the last day of the third month following the month in which the notification was received.

Late Enrollment Penalty (Also referred to as "Higher Premium Charge")

42 CFR §423.46 provides for a late enrollment penalty for Part D eligible individuals who enroll in a Part D drug plan after experiencing a lapse in creditable prescription drug coverage for any continuous period of sixty-three (63) days or longer after the end of their initial Part D enrollment period. The higher premium charge is based on the number of months that the individual did not have creditable coverage. The premium that would otherwise apply is increased by at least 1% of the base beneficiary premium (which is set by CMS and published each year) for each month without creditable coverage. This penalty may apply for as long as the individual remains enrolled in Part D. The individual's higher premium charge will be recalculated each year, because the base beneficiary premium changes annually.

Part D eligible individuals who remain covered under a prescription drug plan that is providing creditable prescription drug coverage will not be assessed a late enrollment penalty if they enroll in Medicare prescription drug coverage within the required time frames at a later date. Individuals who involuntarily lose creditable prescription drug coverage will have a sixty (60) day Special Enrollment Period (SEP) to enroll in a Part D plan. However, they may be assessed a late enrollment penalty if they choose to drop coverage, or lose coverage, and do not promptly take advantage of the resulting Special Enrollment Period. If they go without any creditable coverage for a continuous period of 63 days or longer they may be subject to a late enrollment penalty.

Medicare eligible individuals that delay enrolling in Part D coverage may be required to provide proof that they have maintained creditable prescription drug coverage since the end of their initial enrollment period for Part D. Otherwise, the individual may be subject to the late enrollment penalty. Proof of creditable coverage prescription drug coverage can include, but is not limited to: copies of any disclosure notices provided to them by any entity(s) that provided prescription drug coverage.

Generally, Part D eligible individuals, who are covered under a prescription drug plan that is not creditable prescription drug coverage, need to enroll in a Part D plan during their Initial Enrollment Period for Part D if they do not want to be subject to a late enrollment penalty when they enroll in a Medicare drug plan at a later time. There are limited times each year in which beneficiaries can enroll (including the Annual Coordinated Election Period from November 15th to December 31st each year), and if they do not enroll during their initial open enrollment period, they may pay a late enrollment penalty if they choose to join at a later time.

DISCLAIMER: The above information regarding late enrollment penalties under Medicare is intended to give entities general information regarding the provisions contained in the regulation at 42 CFR §423.46 and §423.286 (c)(3) and in 70 Fed. Reg. 13397, 13399 (March 21, 2005).

Creditable Coverage Definition and Determination

As defined in 42 CFR §423.56(a), coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

This determination is identical to the first prong of the actuarial equivalence test (gross test) that is applied in 42 CFR §423.884 when an employer or union applies for the retiree drug subsidy under that section. It does not take into account whether or to what degree the coverage is financed by the individual or entity.

For plans that have multiple benefit options, the regulation requires that entities apply the actuarial value test separately for each benefit option. A benefit option is defined in 42 CFR §§423.882 as a particular benefit design, category of benefits, or cost- sharing arrangement offered within a group health plan.

III. POLICY GUIDANCE

The following are clarifications and other guidance relating to the above requirements:

Attestation

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the entity is an employer or union electing the retiree drug subsidy. *See* 42 CFR §423.884(d).

Benefit Designs for Simplified Determination of Creditable Coverage Status

If an entity is not an employer or union that is applying for the retiree drug subsidy, it can use the simplified determination of creditable coverage status annually to determine whether its prescription drug plan coverage is creditable or not. The plan will be determined to be creditable if the prescription drug plan design meets all four of the standards set forth below. However, the standards listed under 4(a) and 4(b) below may not be used if the entity's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e., medical, dental, etc.). Integrated plans must satisfy the standard in 4(c).

A prescription drug plan is deemed to be creditable if it:

1. Provides coverage for brand and generic prescriptions;
2. Provides reasonable access to retail providers;
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
4. Satisfies at least one of the following:

    a. The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    b. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    c. For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

Integrated Plan

An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

1. a combined plan year deductible for all benefits under the plan,
2. a combined annual benefit maximum for all benefits under the plan, and/or
3. a combined lifetime benefit maximum for all benefits under the plan.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet steps 1, 2, 3 and 4(c) of the simplified method If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet steps 1, 2, 3 and either 4(a) or 4(b).

NOTE: If the entity cannot use the Simplified Determination method stated above to determine the creditable coverage status of the prescription drug plan offered to Medicare eligible individuals, then the entity must make an actuarial determination annually of whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

Content of Creditable/Non-Creditable Coverage Disclosures from Entity to Beneficiaries.

CMS has provided model/sample language that entities can (but are not required to) use when disclosing creditable coverage status to beneficiaries. CMS issued initial Model Disclosure Notices in May 2005 to be used for the period of November 15, 2005 through May 14, 2006. Model Creditable and Non-Creditable disclosure notice language that entities can use for annual disclosure to new plan enrollees (those with Part D Initial Enrollment Periods on or after May 15, 2006), for use upon request by a Medicare eligible individual, and for use in future plan years have been posted on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

CMS recommends that entities complete the personalized box on of the Model Creditable and Non-Creditable Disclosure Notice if an individual requests a copy of a disclosure notice. Individuals may submit a copy of a personalized disclosure notice as proof of prior creditable coverage when enrolling in a Part D plan. If the entity chooses to not use the Model Disclosure Notices, they can provide a personalized statement of creditable coverage which contains all of the following elements:

- individual's first and last name;
- individual's date of birth or unique member identification number;
- entity name and contact information;
- statement that the entity's plan was determined by the entity to be creditable or non-creditable coverage; and
- The date ranges of creditable coverage.

ENTITIES THAT CHOOSE NOT TO USE THE MODEL/SAMPLE DISCLOSURE NOTICE LANGUAGE MUST PROVIDE DISCLOSURE NOTICES THAT MEET THE FOLLOWING CONTENT STANDARDS:

Content of Coverage Disclosures from Entity to Beneficiaries – Creditable Coverage

If the prescription drug coverage offered by the entity is determined to be Creditable Coverage, a disclosure notice will be considered to meet these requirements if it addresses the following information elements:

1. That the entity has determined that the prescription drug coverage it provides is creditable;
2. The meaning of creditable coverage, i.e., that the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan in the applicable year for which the disclosure notice is being provided is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average; and
3. An explanation of why creditable coverage is important and a caution that even though coverage is creditable, the person could be subject to payment of higher Part D premiums if the person subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.

CMS recommends that the entities also provide the following clarifications in their disclosure statements:

- An explanation of an individual's rights to a notice, i.e., the times when an individual can expect to receive a notice and the times that an individual can request a copy of the notice.

- An explanation of the benefit plan provisions/options that affect Part D eligible individuals (or their dependents) that are related to Part D and their benefit plan. These options may include, for example:
  - that they can retain their existing coverage and choose not to enroll in a Part D plan; or
  - that they can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.
  - if their existing prescription drug coverage is under a Medigap policy, that they cannot have both their existing prescription drug coverage and Part D coverage, and that if they enroll in Part D coverage, they should inform their Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

Recommended CMS language insert for Medigap insurers:

If you decide you do not want to enroll in one of the new plans that provide Medicare prescription drug coverage, you can keep your current Medigap policy without changes. However, you cannot have prescription drug benefits from both a Medigap policy with [Name of Entity] and a Medicare prescription drug plan at the same time. So if you enroll in one of the plans that provide Medicare prescription drug coverage and wish to keep your Medigap policy, please let us know as soon as possible. Federal law requires us to remove the prescription drug benefit from your Medigap policy and your premium will be adjusted.

If you choose to get your Medicare prescription drug coverage through a Medicare Advantage plan, which is a company such as an HMO that contracts with the federal government to provide your Medicare benefits, you may decide it is best for you to cancel your Medigap policy with [Name of Entity]. This is because a Medigap policy can't work with a Medicare Advantage plan.

In making your decision about what to do, please keep in mind that recent changes in law require us to make certain changes to our Medigap plans. These changes will have an effect on future premiums, especially for policies with drug benefits. Please contact us so we can discuss the likely differences in premiums over time among your different choices.

- Whether the covered individuals and/or their covered dependents will still be eligible to receive all of their current health coverage if they or their dependents enroll in a Medicare prescription drug plan.

Recommended CMS language:

Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will [or will not] still be eligible to receive all of your current health and prescription drug benefits.

- A clarification of the circumstances (if any) under which the individual could re-enroll in his/her prescription drug coverage if they drop their current coverage and enroll in Medicare prescription drug coverage and later drop the Medicare coverage. (For Medigap insurers, a clarification that the individual cannot get his/her prescription drug coverage back under such circumstances).

Recommended CMS language- Non-Medigap Issuers:

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may (or may not) enroll back into the [Name of Entity] benefit plan during an open enrollment period under the [Name of Entity] benefit plan.

Recommended CMS language- Medigap Issuers:

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you cannot get back the prescription drug benefits in the [Name of Entity] Medigap policy.

- Information on how to get extra help paying for a Medicare prescription drug plan including the contact information for the Social Security Administration (SSA).

Recommended CMS language:

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Content of Coverage Disclosures from Entity to Beneficiaries – Non-Creditable Coverage

If the prescription drug coverage offered by the entity is determined to be Non- Creditable Coverage, the disclosure notice to the individual a disclosure notice will be considered to meet these requirements if it addresses the following information elements in its Non-Creditable Coverage Disclosure Statement:

1. That the entity has determined that the prescription drug coverage it provides is not creditable;
2. The meaning of creditable coverage, i.e., that the amount the plan expects to pay

on average for prescription drugs for individuals covered by the plan in the applicable year is less than what standard Medicare prescription drug coverage would be expected to pay on average;
3. That an individual generally may only enroll in a Part D plan from November 15th through December 31st of each year; and
4. An explanation of why creditable coverage is important and that the individual may be subject to payment of higher Part D premiums if the person fails to enroll in a Part D plan when first eligible.

CMS recommends that the entities also provide the following clarifications in their disclosure statements:

- An explanation of an individual's rights to a notice, i.e., the times when a individual can expect to receive a notice and the times that an individual can request a copy of the notice.

    - An explanation of the benefit plan provisions/options that affect Part D eligible individuals (or their dependents) that are related to Part D and their benefit plan. These options may include, for example:
    - that they can retain their existing coverage and choose not to enroll in a Part D plan; or
    - that they can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.
    - if their existing prescription drug coverage is under a Medigap policy, that they cannot have both their existing prescription drug coverage and Part D coverage, and that if they enroll in Part D coverage, they should inform their Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium, as of the date the Part D coverage starts.

Recommended CMS language insert for Medigap insurers:

If you decide you do not want to enroll in one of the new plans that provide Medicare prescription drug coverage, you can keep your current Medigap policy with [Name of Entity] without changes. However, you cannot have prescription drug benefits from both a Medigap policy and a Medicare prescription drug plan at the same time. So if you enroll in one of the plans that provide Medicare prescription drug coverage and wish to keep your Medigap policy, please let us know as soon as possible. Federal law requires us to remove the prescription drug benefit from your Medigap policy and your premium will be adjusted.

If you choose to get your Medicare prescription drug coverage through a Medicare Advantage plan, which is a company such as an HMO that contracts with the federal government to provide your Medicare benefits, you may decide it is best for you to cancel your Medigap policy with [Name of Entity]. This is because a Medigap policy can't work with a Medicare Advantage plan.

In making your decision about what to do, please keep in mind that recent changes in law require us to make certain changes to our Medigap plans. These changes will have an effect on future premiums, especially for policies with drug benefits. Please contact us so we can discuss the likely differences in premiums over time among your different choices.

- Whether the covered individuals and/or their covered dependents will still be eligible to receive all of their current health coverage if they or their dependents enroll in a Medicare prescription drug plan.

  Recommended CMS language:

  Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will [or will not] still be eligible to receive all of your current health and prescription drug benefits.

- A clarification of the circumstances (if any) under which the individual could re-enroll in his/her prescription drug coverage if they drop their current coverage and enroll in Medicare prescription drug coverage. (For Medigap insurers, a clarification that the individual cannot get his/her prescription drug coverage back under such circumstances).

  Recommended CMS language- Non-Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may (or may not) enroll back into the [Name of Entity] benefit plan during the open enrollment period under the [Name of Entity] benefit plan.

  Recommended CMS language- Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you cannot get back the prescription drug benefits in the [Name of Entity] Medigap policy.

- Information on how to get extra help paying for a Medicare prescription drug plan including the contact information for the Social Security Administration (SSA).

  Recommended CMS language:

  For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325- 0778).

Alternative Form and Manner of Coverage Disclosure from Entity to Beneficiaries

This guidance clarifies that entities have flexibility in the form and manner of providing Disclosure Notices to beneficiaries. The notice need not be sent as a separate mailing. The Disclosure Notice may be provided with other plan participant information materials (including enrollment and/or renewal materials). The entity may provide a single disclosure notice to the covered Medicare individual and all his/her Medicare eligible dependent(s) covered under the same plan. However, the entity is required to provide a separate disclosure notice if it is known that any spouse or dependent that is Medicare eligible resides at a different address than from where the participant/policyholder materials were provided.

Plan Sponsors may use the electronic disclosure requirements outlined at 29 CFR §2520.104b-1(c)(1) to meet the creditable coverage disclosure requirements under 42 CFR §423.56(c). These requirements allow the entity sponsoring a group health plan to provide a creditable coverage disclosure notice electronically to plan participants who have the ability to access electronic documents at their regular place of work if they have access to the plan sponsor's electronic information system on a daily basis as part of their work duties. If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

An entity can also provide a Disclosure Notice through electronic means to retirees only if the Medicare eligible individual has indicated to the entity that s/he has adequate access to electronic information. An entity must not take the right to provide materials to an individual via electronic means as a permissible way to deliver documents to all individuals. Before individuals agree to receive their information via electronic means, they must be informed of their right to obtain a paper version, how to withdraw their consent, how to update address information, and be advised of any hardware or software requirements needed to access and retain the creditable coverage disclosure.

If the individual consents to an electronic transfer of the notice, a valid e-mail address must be provided to the entity and the consent from the individual must be submitted electronically to the entity. This ensures the individual's ability to access the information as well as ensures that the system for furnishing these documents results in actual receipt. In addition to having the disclosure notice sent to the individual's email address, the notice (except for personalized notices) must be posted on the entity's website, if applicable, with a link on the entity's home page to the creditable coverage disclosure notice.

If entities choose to incorporate disclosures with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure notice portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page of the provided plan participant information.

Example of reference to creditable or non-creditable coverage requirements:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details.

Timing of Creditable Coverage Disclosure from Entity to Beneficiaries

42 CFR §423.56(f) specifies the times when creditable coverage disclosures must be made to Part D eligible individuals. At a minimum, disclosure must be made at the following times:

1. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) – beginning November 15th through December 31st of each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D, as described under §423.38(a);
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. Upon request by the individual.[1]

If the creditable coverage disclosure notice is provided to all plan participants annually, prior to November 15th of each year, CMS will consider items 1 and 2 to be met.

This guidance clarifies that "prior to" means that the individual must have been provided the Disclosure Notice within the past twelve months.

III. CONTACT FOR FURTHER INFORMATION

If you would like further information on creditable coverage, visit the CMS website link related to creditable coverage issues at: http://www.cms.hhs.gov/creditablecoverage

IV. LINK TO THE MODEL CREDITABLE, NON-CREDITABLE AND PERSONALIZED CREDITABLE COVERAGE DISCLOSURE NOTICES TO BE USED ON OR AFTER JANUARY 1, 2009

a. **Model Individual Creditable Coverage Disclosure Notice**
b. **Model Individual Creditable Coverage Disclosure Notice – Spanish**
c. **Model Individual Non-Creditable Coverage Disclosure Notice**
d. **Model Individual Non-Creditable Coverage Disclosure Notice – Spanish**

http://www.cms.hhs.gov/creditablecoverage

[1] Unlike some entities such as group health plans, Medigap issuers do not cover individuals until **after** they are enrolled in Medicare. Moreover, as of January 1, 2006, Medigap issuers cannot offer for sale any policies with prescription drug coverage. Therefore, only situations 1, 4 and 5 apply to Medigap issuers.

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). If you would like more information on maternity benefits, call your plan administrator at (201) 508-4990.

SPARC HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by SPARC health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Premium PPO, Standard PPO, CDHP, Delta Dental PPO, Delta Dental DHMO, Eyemed Standard, Eyemed Enhanced, Anthem EAP, Health Equity FSA and HRA .The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not SPARC as an employer — that's the way the HIPAA rules work. Different policies may apply to other SPARC programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with SPARC

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to SPARC for plan administration purposes. SPARC may need your health information to administer benefits

under the Plan. SPARC agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Benefits department are the only SPARC employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and SPARC, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to SPARC, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to SPARC information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that SPARC cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by SPARC from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects

Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint

- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances

- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1st, 2024. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice via web posting at sparcbenefits.com.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, please contact the VP of Total Rewards.

Misty Nahoopii
SPARC Group LLC
VP Total Rewards, Human Resources
125 Chubb Avenue, 4th Floor
Lyndhurst, NJ 07071
425.221.2807

Complaints
For more information on the Plan’s privacy policies or your rights under HIPAA, contact the VP of Total Rewards, Misty Nahoopii, at 425.221.2807.

Women's Health and Cancer Rights Act 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. If you would like more information on WHCRA benefits, call your plan administrator at (201) 508-4990.

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, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)