Sweet Briar College

Member of the VPC Benefits Consortium

2019 Open Enrollment

Our Benefits Consortium: A Success!

January 1, 2019 will mark the ninth anniversary of the formation of the Virginia Private Colleges Benefits Consortium (VPCBC) and we are pleased to report the state of our own Benefits Consortium is strong. As a member of the Consortium, we are part of a 7,000-life group and are enjoying the negotiating leverage and risk sharing advantages envisioned by its founders more than 10 years ago.

This success has not been achieved without challenges. Last year the Consortium made pharmacy benefit changes to address the challenge of rising drug therapies. We are excited to report there will be no changes to the schedule of benefits for 2019!

Anthem Blue Cross and Blue Shield, MedImpact, Delta Dental and UniView will continue to provide excellent medical, pharmacy, dental and vision benefits, respectively.

Our history of premium rate increases continues to beat Virginia averages - a benefit of our membership in the Consortium. As a member, we also avoid large swings in our year-to-year premium increases by sharing our claims experience with 16 other like-minded private colleges across Virginia.

The Sweet Briar College Medical and Prescription Drug Program

For the 2019 plan year, Sweet Briar College will continue to offer two medical plan options through our alliance with Anthem Blue Cross Blue Shield and MedImpact. Specifically, employees may elect to participate in Plan 4 or Plan 6. **The medical and pharmacy schedule of benefits remain unchanged. PLEASE NOTE: Pharmacy coupons are still accepted but the value of the coupons will no longer count toward satisfaction of deductible, coinsurance or out-of-pocket costs.**

For 2019, all medical plan options are non-grandfathered and are fully compliant with the required provisions established through national Health Care Reform legislation.

The Anthem customer service number for all plans is 1-833-597-2358. This number is on your Anthem ID card.

The dedicated customer service number for MedImpact (prescription drugs) is 1-844-401-1903. If you are not currently enrolled with MedImpact, please provide the customer service representative with the appropriate Guest ID which is based on the "Plan" you are asking questions on. Guest IDs are noted below.

Plan Name	MedImpact Guest ID
Plan 4	VPCPLAN4
Plan 6	VPCPLAN6

To help with the exploration of the drug formulary, drug costs and pharmacy locations, MedImpact has a customized portal available to any VPC eligible member: https://mp.medimpact.com/VPCBC.

New for January 1, 2019: MedImpact will apply your actual out of pocket expense to your deductible and/or out of pocket maximum when using a manufacturer's coupon. Under this program, the amount you accumulate toward your deductible and/or out of pocket cost will not include the manufacturer's copay assistance and your true cost will be credited to your deductible and out of pocket maximum. See example below:

	Current	1/1/2019
Prescription Drug Cost (Your Cost w/o Coupon)	$200	$200
Less Manufacturer Coupon Assistance	($195)	($195)
Actual Member Out of Pocket Expense (Actual Cost You Pay for Drug)	$5	$5
Member Accumulator to Deductible/Out of Pocket Maximum	$200 (this amount is overstated since the actual cost was $5)	$5

HealthAdvocate (NEW)

VPC Benefits Consortium has partnered with HealthAdvocate, the nation's leading healthcare advocacy and assistance company, to help members find providers, clarify treatment options and manage your health and well-being. This new service is available to employees, their spouses, dependent children, parents and parents-in-law. Below are just a few items that an advocate can help you:

- Finding the right doctor
- Clarify benefit coverage
- Help schedule appointment and second opinions
- Resolve billing and insurance claim issues
- Assist in transfer of medical records
- Explain conditions
- Help arrange eldercare services

You can reach HealthAdvocate by phone at 866.695.8622, by email at answers@HealthAdvocate.com or online at www.HealthAdvocate.com/VPCBC.

LiveHealth Online

LiveHealth Online, virtual physician visit service, is becoming more popular as a more convenient and cheaper alternative for more routine types of illnesses or injuries. In addition, LiveHealth Online provides psychology visits and breastfeeding support. Employees have access to a board certified physician via mobile device, online or by phone. LiveHealth Online provides convenience, choice, immediate service, low cost and ease of use. Register today at www.livehealthonline.com

LiveHealth Online	Cost
Copay Plans	
Virtual Visit	$10 or $15 copay per visit, dependent on the plan design
Psychology	Copay mirrors the Mental Health office visit copay
HDHP	
Virtual Visit	$49
Psychology	$90-$120 allowable per visit based on whether the member sees a Licensed Counselor or Psychologist
Non-Anthem Members (Virtual Visit)	$49

Health Savings Accounts

Health Savings Administrators is the administrator for our health savings accounts (HSAs). Starting January 1, 2019, you can contribute $3,500 if you have employee only coverage or $7,000 if you have family coverage. Individuals age 55 or older can also make a catch-up contribution of $1,000 anytime during the year in which you turn 55.

Please visit https://healthsavings.com/about-hsas/ for FAQs; information on how HSAs work; to find out what expenses are eligible and for access to savings calculators. You'll also find brief videos on a number of topics including how to set up your account, and how to invest and withdraw funds. HSA Administrators' Customer Service is also available to answer any questions you might have about your account or how to open an HSA. Call 888-354-0697 or email them at askus@HealthSavings.com.

Consortium Dental Benefits

To supplement our group health care platform, Sweet Briar College offers dental coverage as a member of the VPC Benefits Consortium. Member colleges have partnered with **Delta Dental of Virginia**.

To best meet the needs of participants and covered family members, Sweet Briar College offers the choice of two dental plan options. Our employees may select comprehensive dental coverage through the High PPO Plan. For those who do not want coverage for the major repair services covered by the High PPO Plan, modified coverage and lower premiums are available through the Low PPO Plan. Both plans offer full freedom of choice with regard to dentists, and Delta's Premier and PPO network providers are available under both options.

A brief comparison of both dental plan options is presented below:

Plan Provisions	Option 1 – High PPO	Option 2 – Low PPO
Annual Deductible	$50 individual/$150 family	$50 individual/$150 family
Annual Benefit Maximum	$1,250 per person	$1,000 per person
Diagnostic and Preventive Care	100% - no deductible	100% - no deductible
Basic Dental Care	80% coverage	80% coverage
Major Dental Care	50% coverage	No coverage
Orthodontia	50% to $1,000 lifetime benefit	No coverage

To help make the most of our benefit dollars, Delta delivers a feature called “Preventive First”. Simply stated, benefits paid by Delta for preventive care (checkups, cleanings, x-rays, etc.) *will not count* toward the annual benefit maximum. This means all benefit dollars will be preserved to pay for any repair work which may be required (the more costly services).

Important – Waiting Period: Those who elect to enroll in the dental plan during this enrollment period will be subject to a 12-month waiting period which applies to major dental services (crowns, bridges, inlays, onlays, dentures, partial dentures). However, the waiting period can be waived for those who provide proof of 12 months of prior coverage in a plan that covers major services. Please note that the waiting period *does not apply* to preventive services (checkups and cleanings) or basic services (e.g., fillings, extractions, root canals).

To identify dentists who participate with Delta Dental, you can log on to www.deltadentalva.com and click on “Find a Dentist” on the left side of the home page. A full description of Sweet Briar College’s dental program is provided in your enrollment packet.

Vision Benefits

Vision benefits will continue to be offered through UniCare in collaboration with Anthem. The Uniview vision plan offered by UniCare is voluntary. If you elect the vision plan alongside the medical plan, Anthem and UniCare work together to help identify gaps in care and manage your overall health. At open enrollment, all members will need to either elect vision coverage or waive the coverage.

The vision plan offers our members:

- Affordable coverage – there is no change in premium for 2019
- Access to over 32,000 doctors at more than 26,000 locations nationwide, including private opticians/ophthalmologists/optometrists
- Eyeglass lenses AND Contact lenses once every year
- Valuable discounts on materials
- Low copayments for eye exams and corrective eyewear
- Mail order contact lens replacement services
- Customer Service support 7 days a week; and
- Discounts on Lasik surgery through a credentialed, national network of surgeons

Plan highlights for the Sweet Briar College Vision Plan are below:

	UniCare - UniView Vision Plan
Exam/Material Copay	$15/$15
Frequency	Exams: every 12 months Lenses: every 12 months Frames: every 24 months
Lenses/Frames	
Standard Plastic Lenses	Covered in full after $15 copay
Frames	Members can receive both eyeglasses and contact lenses - each have $130 allowance
Contact Lenses	Elective Conventional - $130 retail allowance plus 15% discount on overage Disposable - $130 allowance (no additional discount) Medically necessary covered in full
Contact Lenses (Fitting & Evaluation)	Standard: $0 copay Premium (Specialty): 10% discount off retail; $55 allowance (member pays the difference of discounted retail minus the $55 allowance)
Out-of-Network	$50 exam allowance $100 frame allowance $50 - $110 lens allowance $130 elective contact lenses allowance $210 medically necessary contact lenses allowance

To locate a participating UniCare Vision provider in your area, log on to www.unicare.com and click on “Find a Doctor”. Then select “Vision” as the type of care, “Virginia” for the state and then the plan/network is “UniView Vision”. You can also contact Customer Service at 1-888-884-8428.

Benefit Contributions for 2019

No rate changes for 2019, please note SBC absorbed the cost of a Delta Dental increase

Insurance Premiums		Employee Premium Contribution				SBC Premium Contribution			
Bi-Weekly	Total Premium	Band 1 *0 - $22,600*	Band 2 *$22,601 - $60,320*	Band 3 *$60,321 - $98,040*	Band 4 *> $98,040*	Band 1 *0 - $22,600*	Band 2 *$22,601 - $60,320*	Band 3 *$60,321 - $98,040*	Band 4 *> $98,040*
Medical Insurance									
Medical Insurance Plan 6									
Employee	$218.31	$13.10	$22.92	$ 58.94	$ 76.41	$205.21	$195.39	$159.36	$141.90
Employee + Child	$340.15	$68.03	$76.36	$ 112.25	$ 142.86	$272.12	$263.79	$227.90	$197.29
Employee + Spouse	$450.00	$175.50	$189.00	$ 225.00	$ 254.25	$274.50	$261.00	$225.00	$195.75
Employee + Family	$636.92	$191.08	$213.37	$ 242.03	$ 280.25	$445.85	$423.55	$394.89	$356.68
2 Married Employees @ SBC	$450.00	$99.36	$101.30	$ 103.19	$ 105.12	$350.64	$348.71	$346.82	$344.88
2 Employees @ SBC + Family	$636.92	$139.87	$142.54	$ 145.22	$ 147.96	$497.05	$494.38	$491.70	$488.97

		Band 1 *0 - $22,600*	Band 2 *$22,601 - $60,320*	Band 3 *$60,321 - $98,040*	Band 4 *> $98,040*	Band 1 *0 - $22,600*	Band 2 *$22,601 - $60,320*	Band 3 *$60,321 - $98,040*	Band 4 *> $98,040*
Medical Insurance Plan 4									
Employee	$270.92	$32.51	$39.83	$74.50	$96.18	$238.41	$231.10	$196.42	$174.75
Employee + Child	$420.46	$84.09	$92.50	$126.14	$159.78	$336.37	$327.96	$294.32	$260.69
Employee + Spouse	$556.62	$214.30	$228.21	$261.61	$297.79	$342.32	$328.40	$295.01	$258.83
Employee + Family	$786.92	$243.95	$259.68	$281.33	$330.51	$542.98	$527.24	$505.60	$456.42
2 Married Employees @ SBC	$556.62	$115.83	$118.06	$120.28	$122.51	$440.78	$438.56	$436.33	$434.10
2 Employees @ SBC + Family	$786.92	$165.49	$168.64	$171.16	$175.09	$621.43	$618.29	$615.77	$611.83

Dental Insurance		All Bands	All Bands
Low Plan			
Employee	$10.62	$0.52	$10.10
Employee + One (Child or Spouse	$15.23	$5.13	$10.10
Employee + Family	$32.77	$21.75	$11.02
2 Married Employees @ SBC	$15.23	$0.50	$14.73
2 Employees @ SBC + Family	$32.77	$17.11	$15.66
High Plan			
Employee	$18.46	$7.90	$10.56
Employee + One (Child or Spouse	$28.15	$17.13	$11.02
Employee + Family	$56.31	$44.36	$11.95
2 Married Employees @ SBC	$28.15	$12.50	$15.65
2 Employees @ SBC + Family	$56.31	$39.73	$16.58

Vision Insurance		All Bands	All Bands
Employee	$2.90	$2.90	$0.00
Employee + Child/Children	$4.63	$4.63	$0.00
Employee + Spouse	$4.82	$4.82	$0.00
Employee + Family	$7.55	$7.55	$0.00

Open Enrollment Guidelines

To be sure you fully understand our benefit plans and all of your choices, we will conduct the following meetings:

11/1/2018	9:00 AM	-	3:00 PM
11/2/2018	9:00 AM	-	3:00 PM

All meetings will be held in the Prothro building, and representatives from Anthem, Delta Dental, LD&B and UniCare Vision will be on hand to explain each program and answer any questions you may have.

Sweet Briar College offers cafeteria plan benefits which allow employees to make medical, dental and vision plan contributions on a pre-tax basis. Your contributions will be deducted on a pre-tax basis, unless you instruct us to make these deductions on an after-tax basis.

Important: Our annual Open Enrollment is your opportunity to elect new benefits or change your current coverage. If you choose not to enroll at this time, you'll have to wait until our next open enrollment. After our Open Enrollment period has closed, election changes can only be made during the plan year if you experience a **qualifying event**, such as:

- Change in marital status;
- Dependent loses eligibility for membership (e.g., exceeding the age limit, divorce, etc.);
- New dependent becomes eligible (e.g., newborns, adoptions);
- Change in subscriber's employment;
- Change in hours from part-time to full-time and vice versa;
- Member assumes permanent residence outside the service area;
- Death of a member;
- Availability of other health coverage;
- You or your dependent become eligible for state-granted health premium assistance;
- You or your dependent loses health coverage under Medicaid or a State Children's Health Insurance Program (SCHIP).

Any requested benefit change must be consistent with the status change, and status changes must be requested within **31 days** of the life event. However, if you or a dependent wish to elect health coverage due to (1) being approved for state assistance with health premiums; or (2) the loss of coverage under Medicaid or SCHIP, you must elect coverage within **60 days** of the date you qualify for or lose coverage. In addition, those who may wish to add newborn or adopted children to our benefits program will have **60 days** to enroll.

To be certain that all eligible employees understand their rights under the new Health Care Reform laws and each state's CHIP benefits (Children's Health Insurance Plans), notices which detail these important benefits have been attached to this correspondence.

We look forward to seeing all of you at the upcoming benefit meetings. In the meantime, we encourage you to contact our Human Resources Department if you have any questions concerning the benefits program at Sweet Briar College.


Don't miss
the
Deadline

Vendor Contact Information

Benefit	Provider	Phone/Email	Website
Medical	Anthem	833.597.2358	www.anthem.com
Prescription Drug Services	MedImpact	Customer Service: 844.401.1903 Direct Mail Order Customer Service: 855.873.8739 Direct Specialty Customer Service: 877.391.1103	https://mp.medimpact.com/VPCBC
Blue View Vision	Anthem	833.597.2358	www.anthem.com
LiveHealth Online	Anthem	888.548.3432	www.livehealthonline.com
Medical Travel Internationally	Anthem BlueCross BlueShield Global core (formerly BlueCard Worldwide)	800.810.2583 (BLUE)	www.bcbsglobalcore.com
Dental	Delta Dental	800.237.6060	www.deltadentalva.com
Uniview/Unicare Vision	Unicare	888.884.8428	www.unicare.com
Health Advocate	HealthAdvocate	866.695.8622 Email: answers@HealthAdvocate.com	www.healthadvocate.com/VPCBC
COBRA Administration	LD&B Benefits Administrators	Liz Waybill COBRA Administrator 540.438.4132 Email: lwaybill@ldbbenefitsadmin.com	www.ldbbenefitsadmin.com

REQUIRED NOTICES

Individual Mandate

As part of The Affordable Care Act, most individuals must purchase health insurance coverage or pay a penalty. The source of that coverage can be through your employer, a spouse's employer, an individual policy or some other source. The penalty for going uncovered for 2018 will be $695 per adult or 2.5% of household income in excess of tax filing thresholds, whichever is higher.

Women's Health and Cancer Rights Act Enrollment Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the Deductible and the Coinsurance applies.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Women's Health and Cancer Rights Act Annual Notice

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

Newborns' and Mothers Health Protection Act Enrollment 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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 12/31/2019)

Important Information About Your COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

Sometimes, Filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer for retirees, or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get

up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Please contact the Plan Administrator for additional information.

Your Medical Plan(s) HIPAA 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 IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by your employer to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how your employer, collectively we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to

provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting your Plan Administrator.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include

vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from your Plan Administrator. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be

signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact you Employer's Privacy Office by writing to your Employer.

HIPAA Special Enrollment Model Notice

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

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 enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. 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.

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.

To request special enrollment or obtain more information, contact your Plan Administrator.