2025 Annual Notices

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Introduction

This newsletter contains important information. We encourage you to read all sections. If you have questions regarding any items contained in this newsletter, please contact your Human Resources office or plan administrator for more information.

We hope you find this information helpful and informative.

Summary of Benefits and Coverage

The Health Care Reform law states that all groups must implement the requirement that health plans and health insurers provide consumers with a Summary of Benefits and Coverage (SBC). The stated purpose of the SBC is to "accurately describe the benefits and coverage under the applicable plan or coverage," which will allow participants to better compare plan terms and benefits.

In addition, all group health plans will have to distribute a brief standard summary of benefits and must use and distribute a uniform glossary containing definitions for common terms (e.g. "copay", "deductible", etc.).

This should be distributed annually, no later than December 1st and within seven days per any employee request. The medical SBC will be created by the insurance carrier and provided to each group for distribution.

In addition, if your group has a stand-alone HRA or FSA that covers expenses beyond excepted benefits, then the plan sponsor, not the insurance carrier, will create and distribute that SBC.

Special Enrollment Rights 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days of the other coverage end date (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption. .

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

WHCRA 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. For more information on WHCRA benefits, contact your Plan Administrator.

Patient Protections Disclosure Notice

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier by calling the number on the back of your ID card.

FOR GROUPS WITH HMO PLANS:
The employer's group health plan generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier by calling the number on the back of your ID card.

Notice of Availability of Notice of Privacy Practices

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your group health plan (the Plan) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information (PHI) may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI" PHI is any individually identifiable information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

◊ Your past, present or future physical or mental health or condition;
◊ The provision of health care to you; or
◊ The past, present or future payment for the provision of health care to you.

A copy of the Notice of Privacy Practices is available to all individuals whose PHI will be used or maintained by the Plan. If you any questions about this Notice, please contact your Human Resources office or plan administrator.

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.pennie.com(in Pennsylvania) or 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-KIDSNOW** 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 -

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: **http://www.njfamilycare.org/index.html**

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website:

https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

PENNSYLVANIA – Medicaid

Website:

https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: 1-800-692-7462

CHIP website: Children'sHealthInsuranceProgram(CHIP)pa.gov

CHIP Phone: 1-800-986-KIDS (5437)

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

OMB Control Number 1210-0137 (expires 01/31/2026)

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

FLORIDA– Medicaid
Website: **https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268

VIRGINIA – Medicaid and CHIP
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

To see if any other states have added a premium assistance program since July 31, 2023 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

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. Contact the Pennsylvania Insurance Department at www.insurance.pa.gov/nosurprises or by phone at 1-877-881-6388 or TTY/TDD: 717-783-3898 if you have difficulty finding a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  * Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  * Cover emergency services by out-of-network providers.
  * Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  * Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Pennsylvania Insurance Department at **www.insurance.pa.gov/nosurprises** or by phone at **1-877-881-6388 or TTY/TDD: 717-783-3898.**

Visit **www.insurance.pa.gov/nosurprises** for more information about your rights under federal and state law. You may also visit https://www.cms.gov/nosurprises for information from the federal government.

Notice of Dependent Enrollment Limitations

Newborns: Must be enrolled within **30 days** of birth. If they are not enrolled within this time frame, they are not eligible until the next open enrollment period. If no open enrollment period exists, they are not eligible until a Life Status Event occurs (which may not occur in many instances).

Adoption/Judgments/Decrees/Etc.: Must be enrolled as of effective date listed on legal documentation. Refer to Plan Document on day limitation (i.e. 30 or 60 days to enroll).

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less cesarean section.

However, Federal law generally does not prohibit the mother's or newborns 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 (or96 hours).

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