Lawley Benefits U

KEEPING YOU INSURED AND INFORMED

Employee Benefit Annual Compliance Chart
Notice, Disclosure, and Reporting Rules

November 2011

The following chart is a summary of basic disclosure and reporting requirements that apply to group health plans and/or employers under various employee benefit and employment laws. These notices should be communicated during open and regular enrollments, if applicable to your plan. Note that not all disclosure and reporting requirements are reflected in this chart. Users of this chart should refer to the specific federal law at issue for complete information.

Links have been provided in the chart below for the Department of Labor's model notices, where available. In addition, model notice language can also be found at http://www.dol.gov/ebsa/pdf/CAGAppC.pdf. Finally, a sample of some of the notices can be found at the end of this document.

Law	Governs	Notice Requirement	Summary
Health Care Reform	Group health plans and health insurance issuers, if applicable to specific plan desgin	**Statement of grandfathered status** - Plan administrator or issuer should provide first statement before the first plan year beginning on or after Sept. 23, 2010. Must continue to be provided on a periodic basis with any participant materials describing plan benefits, until grandfathered status is lost.	Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, (the enactment date for health care reform) that satisfy certain requirements. Grandfathered plans can avoid many of the new health care reform provisions. To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description (SPD) and open enrollment materials). The DOL's model notice is available at: http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc
		Notice of patient protections and selections of providers – Plan administrator or issuer must provide notice of new patient protections whenever the SPD or similar description of benefits is provided to a participant. The first notice should be provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010.	Group health plans (non grandfathered) and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care. The DOL's model notice is available at: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc
COBRA	Employers that had 20 or	**Initial/General COBRA notice** – Plan administrator must provide	Notice to covered employees and covered spouses of the right to purchase temporary extension of group health

Law	Governs	Notice Requirement	Summary
	more employees on more than 50% of the typical business days during the previous calendar year Government and church plans are exempt	generally within 90 days of when group health plan coverage begins	coverage when coverage is lost due to a qualifying event. The DOL's model General COBRA Notice is available at: http://www.dol.gov/ebsa/modelgeneralnotice.doc
ERISA	ERISA employee welfare benefit plans, unless exempted	**Summary plan descriptions** - Plan administrator must provide automatically to participants within 90 days of becoming covered by the plan (though a new plan has 120 days after becoming subject to ERISA to distribute SPD) Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.	SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan.
		Summary of material modification – Plan administrators must provide automatically to participants within 210 days after the end of the plan year in which the change is adopted If benefits or services are materially reduced, participants must be provided notice within 60 days from adoption; or, where participants receive such information from the plan administrator at regular intervals of not more than 90 days, notice of materially reduced benefits or services must be provided within the regular interval.	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.
		Summary annual report –Plan administrators must provide automatically to participants within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension). Plans that are exempt from the annual 5500 filing requirement are not required to provide an SAR. Large, completely unfunded health plans are also generally exempt from the SAR	The summary annual report is a narrative summary of the Form 5500 and includes a statement of the right to receive the annual report. Model notices are found in 29 CFR 2520.104b-10(d).

Law	Governs	Notice Requirement	Summary
		requirement.	
		Form 5500 – generally must be filed by the last day of the seventh month following the end of the plan year, unless an extension has been granted. For calendar year plans, the deadline is normally July 31st of the following year.	Form 5500 filing requirements vary according to type of filer (i.e., small plans, large plans and direct filing entities). Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The DOL Internet site at http://www.dol.gov/EBSA/5500MAIN.html and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.
HIPAA-Wellness Programs	Group health plans and insurers that offer Wellness Programs which condition a reward based on outcome	**Notice of Alternative Standard** - Plans and insurers must disclose the availability of an alternative standard in all materials describing the wellness program.	Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA's nondiscrimination rules unless the program satisfies a number of conditions: • Limit reward to 20% of cost of coverage; • Design to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard.
HIPAA-Privacy and Security	Covered Entities: Group health plans, health care clearing-houses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies Business Associates: service providers to Covered Entities that use protected health information (PHI)	**Notice of Privacy Practices** – The plan administrator or insurer must provide the Notice of Privacy Practices when a participant enrolls, upon request and within 60 days of a material revision to the notice. At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices. Generally, fully insured health plans with no access to PHI and self insured plans with less than 50 participants are exempt from most privacy requirements.

Law	Governs	Notice Requirement	Summary
HIPAA-Portability	Group health plans and issuers of group health plan insurance coverage, unless exception applies	**Notice of special enrollment rights** – Plan administrators must provide at or before the time an employee is initially offered the opportunity to enroll in the group health plan.	Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of the loss of coverage under a Medicaid plan or CHIP, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.
Newborns' and Mothers' Health Protection Act (NMHPA)	Group health plans that provide maternity or newborn infant coverage	**NMHPA Notice** - Plan administrators must include a statement within the SPD (or SMM) timeframe.	The plan's SPD must include a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the different areas and the federal or state requirements applicable in each.
CHIPRA	Employers that maintain group health plans covering employees in states that provide premium assistance subsidies under a Medicaid plan or CHIP	**Annual Employer CHIP Notice** First annual notice must be sent by the first day of the first plan year beginning after Feb. 4, 2010 and annually thereafter.	States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in that state. Employers may use the model notice provided by the DOL as a national notice to meet their obligations under CHIPRA. The notice may be provided in writing by first-class mail or electronically if DOL electronic disclosure requirements are satisfied. For a copy of the model notice, see: www.dol.gov/ebsa/pdf/chipmodelnotice.pdf.
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	**Annual Disclosure Notices for creditable or non-creditable coverage** – At a minimum, must be provided by the plan sponsor at the following times: 1) Prior to the Medicare Part D Annual Coordinated Election Period – Oct. 15 through Dec. 7 of each year; 2) Prior to an individual's Initial Enrollment Period for Part D; 3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; 4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or	Group health plan sponsors — or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals — must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage. Model forms are available from the Centers for Medicare & Medicaid Services (CMS) at: www.cms.gov/creditablecoverage/.

Law	Governs	Notice Requirement	Summary
		becomes creditable; and 5) Upon request by a Medicare Part D eligible individual. *If the plan sponsor provides notice to all participants annually, CMS will consider #1 and #2 above to be met. "Prior to" means in the prior 12 months.	
		Disclosure to CMS – Plan sponsor must make disclosure on an annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change)	Employers must disclose to CMS whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form on the CMS web page at: http://www.cms.gov/CreditableCoverage/40_CCDisclosure.asp#TopOfPage unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.
Women's Health and Cancer Rights Act (WHCRA)	Group health plans that provide coverage for mastectomy benefits	**Annual WHCRA Notice** – Plan administrators and issuers must provide notice upon enrollment in the plan and annually thereafter.	The DOL has published sample language for both the enrollment notice and the annual notice. Enrollment notice should include a statement that for participants and beneficiaries who are 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. Notice should also include a description of any deductibles and coinsurance limitations applicable to such coverage. Annual notice should include a copy of the WHCRA enrollment notice, or a simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description.

This Lawley Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Model Grandfathered Plan Status Notice

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

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

Model Patient Protections Notice

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

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

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

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

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

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

Model General Notice Of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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."

[*If the Plan provides retiree health coverage, add the following paragraph:*]

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 [*enter name of employer sponsoring the plan*], 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 with respect to the bankruptcy. 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee

became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Plan Contact Information

[*Enter name of group health plan and name (or position), address and phone number of party or parties from whom information about the plan and COBRA continuation coverage can be obtained on request.*]

Model Wellness Program Disclosure

For group health plans offering a wellness program that requires an individual to satisfy a standard related to a health factor, the following is model language that may be used to satisfy the requirement that the availability of a reasonable alternative standard be disclosed:

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.

Model Special Enrollment Notice

The following is language that group health plans may use as a guide when crafting the special enrollment 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 [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

Model Newborns' Act Disclosure

The following is language that group health plans subject to the Newborns' Act may use in their SPDs to describe the Federal requirements relating to hospital lengths of stay in connection with childbirth:

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

Plans subject to State law requirements will need to prepare SPD statements describing any applicable State law.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268

Phone (Maricopa County): 602-417-5437	
CALIFORNIA – Medicaid	**GEORGIA** – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-8183
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nc.gov Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp Phone: 1-866-435-7414

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current [Insert Name of Entity] coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current [Insert Name of Entity] coverage, be aware that you and your dependents will [or will not] [Medigap issuers must insert *"will not "*] be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information [or call [Insert Alternative Contact] at [(XXX) XXX-XXXX]. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE

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).

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

Medicare Eligible Individual's Name: [Insert Full Name of Medicare Eligible Individual]
Individual's DOB or unique Member ID: [Insert Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]
From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date:	[Insert MM/DD/YY]
Name of Entity/Sender:	[Insert Name of Entity]
Contact--Position/Office:	[Insert Position/Office]
Address:	[Insert Street Address, City, State & Zip Code of Entity]
Phone Number:	[Insert Entity Phone Number]

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. OMB 0938-0990

Model WHCRA Enrollment Notice

The following is language that group health plans may use as a guide when crafting the 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. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

Model WHCRA Annual Notice

The following is language that group health plans may use as a guide when crafting the WHCRA annual notice:

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