Benefit Notices for New Hires

Employers with 50 or More Employees

This packet is designed for employers with 50 or more employees, with templates and practical tips to prepare the benefit notices you need.

Benefit Notices for New Hires

Employers with 50 or More Employees

Employers sponsoring group health plans must provide certain notices and disclosures to eligible individuals when they first become eligible for or enrolled in benefits. These materials often are referred to as "new hire benefit notices" or "initial enrollment benefit notices." This printable guide contains the notices and templates to prepare required benefit notices. Also available is a simplified chart with links to each item for downloading on demand.

Mineral has prepared this Guide in MS Word format to make it quick and easy for employers and their advisors to copy the notices they need (and skip the others!) and fill in plan names, contact information, and other required items to create final notices for their use.

To get started, see the list of notices contained in this package along with guidance about which notices to include for your plan. Then just copy the notices you need and customize them with your plan's information. *For convenience, variables and fill-in items are **highlighted in orange***.

Insured Health Plans: Plans provided through group insurance policies are subject to state insurance laws that may apply in addition to, or in place of, one or more of the federal notices in this package. In that case, the insurance carrier provides the applicable notice(s) which may be distributed with enrollment materials or included in the carrier's evidence of coverage (EOC) booklet. Employers are advised to coordinate with the carrier to ensure that all requirements are met under both federal and state law.

HIPAA Privacy Notices: Employers who sponsor one or more group health plans that are subject to Privacy and Security Rules under the Health Insurance Portability and Accountability Act (HIPAA) may be responsible for their plan's compliance with the rules, including the requirement to prepare and distribute a Notice of Privacy Practices (Privacy Notice) to plan participants. The requirements vary widely, depending on whether the plan is insured or self-funded, the extent to which the employer has access to personal health information (PHI), the use of electronic media, and other factors. Due to these variables, Privacy Notices are outside the information provided here, and employers are advised to review their plan or plans with legal counsel offering expertise in HIPAA.

Multiemployer Plans, Multiple Employer Welfare Arrangements, and Association Health Plans: This material is designed for use by *single-employer plans only*. Do not use for multi-employer plans (e.g., union trusts), multiple employer welfare arrangements (MEWAs), or association health plans.

Notice	When to Use the Notice
Disclosure of Grandfathered Plan Status Spanish Notice	Use this notice only for a group health plan that maintains grandfathered plan status, as defined by the Affordable Care Act (ACA). If using, fill in plan name and other information where indicated to create final copy.
Disclosure of HIPAA Opt-Out	Use this notice only for a self-funded nonfederal governmental plan that has opted out of certain federal benefit mandates, such as mental health parity. *This is uncommon*. If using, fill in plan name and other information where indicated to create final copy.
Employer CHIP Notice English Notice Spanish Notice	Use this notice if group health coverage is offered to persons who live in any one of the states listed in the notice. For convenience, this notice may be distributed to all persons eligible for group health coverage, regardless of location. Do not attach this notice to other material. It must stand alone, so it is not included in this package.
Employer Exchange Notice Spanish Notice I Spanish Notice II	**REQUIRED notice to all new employees**, regardless of eligibility for any employer-sponsored benefits. Distribute within 14 days of hire. Use first template for employers who offer group health coverage to at least some employees or use second template for employers who do not offer group health coverage to any employees, as appropriate, then fill in employer and coverage information where indicated to create final copy.
General Notice of COBRA Rights Spanish Notice	Use this notice for new group health plan enrollees. Complete variable items with appropriate text. **Caution:** Most employers use an outside COBRA administrator. In that case, consult with vendor to determine whether to use this template or the vendor's customized notice.
General Notice of FMLA Rights Spanish Notice	Requirement to provide this notice can be met either by distributing it to FMLA-eligible employees, or by simply including the text in employee handbooks. In either case, the employer must display this FMLA Notice (as a poster) in the workplace.
General Notice of USERRA Rights	This notice is OPTIONAL. Although employers are required to display this USERRA Notice (as a poster) in the workplace, they are not required to distribute it to employees.
Medicare Part D Notice of Creditable Coverage Spanish Notice	Use this notice only if the group health plan's prescription drug coverage is creditable (i.e., equal or superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. If using, complete variable items with appropriate text. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is creditable, include this notice and identify the creditable plan.

Notice	When to Use the Notice
Medicare Part D Notice of Non-Creditable Coverage Spanish Notice	Use this notice only if the group health plan's prescription drug coverage is non-creditable (i.e., is not equal nor superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare-eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. If using, complete the variable items with appropriate text. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is non-creditable, include this notice and identify the creditable plan.
Michelle's Law Notice	All group sizes: Use this notice for a group medical plan that provides dependent coverage beyond age 26 with student status when a dependent child experiences a medically necessary leave of absence from school. Separate distribution is not required if the information in the notice already appears in the plan's SPD.
Newborns' and Mothers' Health Protection Act Notice	Use this notice for a group medical plan that includes maternity and newborn coverage. Separate distribution is not required if the information in the notice already appears in the plan's SPD.
Notice of Patient Protections Spanish Notice	Use this notice for nongrandfathered health plans that allow or require members to designate primary care physicians (PCPs) and/or require preauthorization or referral for other care. If using, fill in plan name and other information where indicated to create final copy. Separate distribution is not required if the information already appears in the plan's SPD.
Notice of Special Enrollment Rights	Use this notice for all group health plans (other than "excepted benefits" such as a stand-alone dental or vision plan, or health FSA, that has not adopted HIPAA's special enrollment rules). Fill in plan name and other information where indicated to create final copy.
Section 125 Cafeteria Plan	All group sizes: Section 125 plan documents must be created and adopted for compliance with Internal Revenue Code § 125 when withholding pre-tax benefits contributions. A summary plan description must be distributed to employees when a health flexible spending or dependent care account is included in a cafeteria plan.
Summary Plan Description	All group sizes: An SPD must be created and distributed.
Summary of Benefits and Coverage, Uniform Glossary	All group sizes: SBCs may be obtained from the insurance carrier and must be provided. A sample SBC template is available, if needed. The Uniform Glossary must also be provided.
Wellness Program Disclosure (ADA)	Use this notice for a wellness program that is subject to the Americans with Disabilities Act (ADA) regarding programs that request health information. If using, fill in plan name and other information where indicated to create final copy.
Wellness Program (GINA General Disclosure)	Use this notice for a wellness program that requests any health information. Employers are prohibited from requesting or requiring genetic information. By providing this notice, any receipt of genetic information generally will be deemed inadvertent and not a violation of the prohibition.

Notice	When to Use the Notice
Wellness Program Disclosure (HIPAA)	Use this notice for a wellness program that is subject to HIPAA's notice requirement regarding reasonable alternative standards to earn a program incentive. If using, fill in plan name and other information where indicated to create final copy.
Women's Health and Cancer Rights Act Notice	Use this notice for group medical plans that cover mastectomies. Note that this is the long notice; a shorter notice is allowed for repeated annual distribution, but most employers prefer using the long form for both initial and annual distribution. If using, fill in plan name and other information where indicated to create final copy.

NOTICES

DISCLOSURE OF GRANDFATHERED PLAN STATUS

This [insert group health plan name] believes this plan 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 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/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental employer plans, insert: You may also contact the Department of Health and Human Services at www.hhs.gov.]

DISCLOSURE TO ENROLLEES REGARDING HIPAA OPT-OUT

Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. We have elected to exempt the plan from [insert "all" or specify which of the following apply] of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a Cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these federal requirements will be in effect for the [insert "plan year" or "period of plan coverage"] beginning [insert beginning date] and ending [insert specific ending date]. The election may be renewed for subsequent plan years.

Per the Genetic Information Nondiscrimination Act (GINA), the opt-out does not prevent the Health Insurance Portability and Accountability Act (HIPAA) portability and nondiscrimination requirements from applying to genetic information. Further, the opt-out does not apply to GINA's restrictions on requesting, requiring, collecting, and using genetic information.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
5. Employer address	6. Employer phone number

7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		

11. Phone number (if different from above)	12. Email address

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? Article II (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ Article I.
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
5. Employer address	6. Employer phone number

7. City	8. State	9. ZIP code

10. Who can we contact at this job?

11. Phone number (if different from above)	12. Email address

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

GENERAL NOTICE OF COBRA RIGHTS
Continuation Coverage Rights Under COBRA

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 [*choose and enter appropriate information:* must pay *or* aren't required to 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."

[*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. 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;
- *[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).

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 [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 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. [*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 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, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have

to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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.

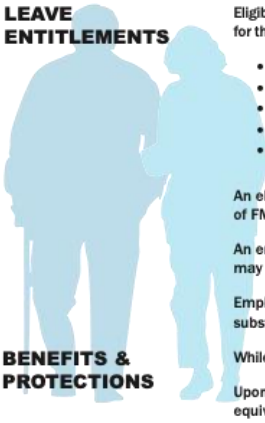
Plan contact information

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

[1] https://www.medicare.gov/sign-up-change-plans

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

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

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

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

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

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

BENEFITS & PROTECTIONS

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

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

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

ELIGIBILITY REQUIREMENTS

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

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

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

REQUESTING LEAVE

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

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

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

EMPLOYER RESPONSIBILITIES

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

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

ENFORCEMENT

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

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

For additional information or to file a complaint:

1-866-4-USWAGE

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

www.dol.gov/whd

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

WAGE AND HOUR DIVISION

WH1420 REV 04/16

GENERAL NOTICE OF USERRA RIGHTS

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer based health plan coverage for you and your dependents for up to 24 months while in the military.

- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

[This Notice is for a Plan that Provides Creditable Coverage]

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

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by [insert name of entity] AND (2) eligible for 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 group health plan name] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [insert name of entity] coverage [insert "will" or "will not"] be affected. [Insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individual 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 Plan 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 coverage, be aware that you and your dependents [insert "will" or "may 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 October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage …

Contact the person listed below for further information at [insert telephone number].
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.

For More Information About Your Options Under Medicare Prescription Drug Coverage …

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: _____

Name of entity/sender: _____

Contact (position/office): _____

Address: _____

Phone number: _____

[This Notice is for a Plan that Provides Non-Creditable Coverage]

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

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by [insert name of entity] AND (2) eligible for 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

3. 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.
4. [Insert name of entity] has determined that the prescription drug coverage offered by the [insert name of group health plan] is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [insert name of group health plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
5. You can keep your current coverage from [insert name of group health plan]. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options

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 decide to drop your current coverage with [insert name of entity] since it is employer group coverage, you will be eligible for a two (2) month Special Enrollment Period

(SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under [insert name of group health plan].

[Insert if previous coverage provided by the entity was creditable coverage: Since you are losing creditable prescription drug coverage under your current plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under [insert name of group health plan] is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 [insert "may" or "will not"] be affected. [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 9 - 11 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 [insert "will" or "will not"] be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage …

Contact the person listed below for further information. 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.

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).

Date: _____

Name of entity/sender: _____

Contact (position/office): _____

Address: _____

Phone number: _____

MICHELLE'S LAW NOTICE

Michelle's Law is a federal law passed in 2008 that extends coverage for a dependent child over the age of 26 when enrolled as a full-time student in post-secondary education prior to a medically necessary leave of absence suffered by the child, which causes the loss of full-time student status.

Group health plan of [employer name] includes eligibility of coverage for an employee's dependent child, defined as an employee's eligible dependent child under Code § 152(f)(1), who is over the age of 26, pursuant to a state-mandated benefit requires full-time student status, who is receiving health coverage as a full-time student in a post-secondary educational institution and who would otherwise lose health coverage because they take a medically necessary leave of absence that would cause the loss of full-time student status, may be entitled to up to one year of continued coverage due to the medically necessary leave.

To be eligible for this extension, the dependent child's treating physician must provide a written certification to the plan administrator that the child is suffering from a serious illness or injury and the leave of absence from the post-secondary institution is medically necessary.

A child on a medically necessary leave of absence is entitled to receive the same plan benefits as other dependent children covered under the plan. Any change to plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other children covered under the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

NOTICE OF PATIENT PROTECTIONS (PCPs)

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

[Insert name of group health plan] generally [insert "requires" or "allows," as applicable] 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, [insert name of group health plan] 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 [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

[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 [insert name of group health plan or insurer] 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 [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) 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 [insert "60 days" or any longer period that applies under the plan] after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within [insert "60 days" or any longer period that applies under the plan] after you or your dependents become eligible for the premium assistance.

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

WELLNESS PROGRAM DISCLOSURE (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTICE REGARDING WELLNESS PROGRAM (ADA)

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, including a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you cannot participate in any of the health-related activities or perform any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information].

The information from your HRA and the results from your biometric screening will provide information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You are also encouraged to share your results or concerns with your doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed

except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information to provide you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach. We will notify you immediately if a data breach occurs involving information you provide in connection with the wellness program.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program. You will not be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice or protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information].

WELLNESS PROGRAM DISCLOSURE (HIPAA)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert name, title, telephone number, and any additional contact information of the appropriate plan representative] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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 brief description of deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].